

Client Health Questionnaire



NOTE FROM COACH:

This questionnaire will allow me to get to know your current health and fitness state. Please answer it to the best of your abilities and be as honest as possible. The key to the success of any health program is the open communication from a client and their coach. If you have any questions please do not hesitate to email or call me.

CLIENT INFORMATION :

Name _____
Phone Number _____
Address _____
Email _____
IG Handle/Facebook _____
DOB _____

Date _____
Height _____
Weight _____
BF% (If known) _____
Gender _____
(Female) Measurements:
Waist: _____ Hips: _____ Thighs: _____ Chest: _____
Neck: _____ Waist : _____ Hips: _____ Thighs: _____

WEEKLY EXERCISE INFORMATION:

Please explain what type of resistance exercises, cardiovascular, or sports activities you perform over a 7-day period.
Exercise Activity: _____

What time do you weight train? _____ Days/ Week _____ Duration _____

LIFESTYLE/PROFESSIONAL ACTIVITY:

How would you rate the level of your profession, or what you do during the day?

Sedentary ☐ Moderate Active ☐ Active ☐ Very Active ☐

WHAT ARE YOUR GOALS?

Lose Weight ☐ Gain Weight ☐ Maintain/Improve Eating Habits ☐ Sport Specific ☐ Improve Flexibility ☐
Muscular Strength/Size ☐ Injury Rehab ☐ Goal Weight ☐ Compete ☐ Competition Date _____

BODY TYPE

Which of the following statements best describes you?

- ☐ I can practically eat anything I want and don't gain weight.
- ☐ I can lose or gain weight by adjusting my activity level.
- ☐ I find it difficult to lose weight. I can gain weight easily and have to watch what I eat.

What time do you wake up? _____ What time do you go to sleep? _____

Do you smoke cigarettes? Y / N How many per day? _____ For how long? _____

Do you drink alcoholic beverages? Y / N

If so, what type of drinks and how many per day? _____

Client Health Questionnaire



HEALTH & MEDICAL CONDITIONS

- | | | | |
|---|---|--|---|
| ☐ Heart Disease | ☐ Hypertension | ☐ Asthma | ☐ Knee Problems |
| ☐ Anemia | ☐ Abnormal EKG | ☐ Emphysema | ☐ Lung Problems |
| ☐ Hypoglycemia | ☐ Arthritis | ☐ Hernia | ☐ Recent Broken Bones |
| ☐ Liver Disease | ☐ Stroke | ☐ Fatigue | ☐ Osteoporosis |
| ☐ Kidney Disease | ☐ Rheumatic Fever | ☐ Foot Problems | ☐ Leukemia or Cancer |
| ☐ Diabetes | ☐ Bursitis | ☐ Back Problems | ☐ Are you pregnant? Y/N |
| ☐ Pancreatic Disease | ☐ Headache/Migraine | ☐ Stomach Problems | ☐ Swollen/Painful Joints |
| ☐ Lactation | ☐ Low Blood Pressure | ☐ Shoulder Problems | ☐ Abnormal Chest X-Ray |

Any other health problems or concerns not mentioned above? Please Describe:

PLEASE INDICATE ANY MEDICATIONS YOU ARE TAKING?

- | | |
|---|--|
| ☐ Diuretics | ☐ Thyroid Meds |
| ☐ Beta-Blockers | ☐ Diabetes/Insulin |
| ☐ Vasodilators | ☐ Calcium Channel Blockers |
| ☐ Cholesterol Meds | ☐ NSAIDS/ Anti-inflammatory |
| ☐ Alpha Blockers | |

Any other medications for other conditions? Please Describe:

OTHER QUESTIONS

Do you have history of any kind of heart disease?

Do you have history of any kind of metabolic disease (thyroid)?

Have you experience any kind of chest pain?

Shortness of breath during exercise?

Have you ever suffered from any problems with faint or dizziness?

Do you have difficulty breathing while standing?

Do you suffer from sleep apnea?

Do you suffer from ankle edema?

Do you have a known heart murmur?

Have you ever experienced severe pain in leg muscles while walking?

Do you have a family history accelerated heart beat or flutters?

Do you have a family history of cardiac or pulmonary disease prior to the age of 55?

Have your serum cholesterol level been measured greater than 240mg/dl?

Have your HDL been measured greater than 60mg/dl?

Client Health Questionnaire



OTHER QUESTIONS

Any other medical condition you may have please list accurately for your safety and well being?

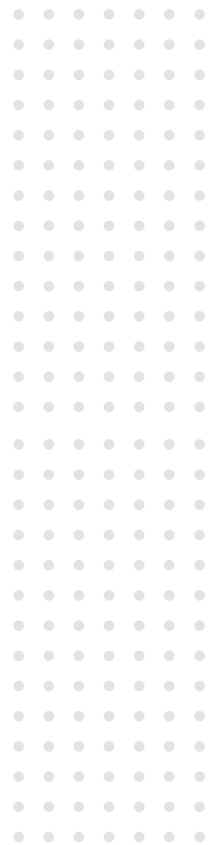
FOOD QUESTIONS

Please list below everything you eat in a 24 hour period. Include supplements, vitamins, snacks, beverages, water, and approximate amount.

1. _____	Time: _____
2. _____	Time: _____
3. _____	Time: _____
4. _____	Time: _____
5. _____	Time: _____
6. _____	Time: _____
7. _____	Time: _____
8. _____	Time: _____

List beverages that you consume daily and supplements.

List any food allergies if any:



Client Health Questionnaire



Make your Favorite Food List

How many meals a day would you prefer to eat?

Choose one:

4 meals

5 meals

6 meals

