

Confidential Health and Lifestyle Questionnaire

Section 1, Personal Details

Name	
Address	
Postcode	
Home Telephone No	
Work Telephone	
E-mail	
Occupations	
Date of Birth	

Section 2, Emergency Contact Details

Name	
Address	
Telephone	

Section 3, your Doctors Details

Name	
Address	
Telephone	

Section 4, your health goals

What health goals would you	
What long term health goals	
Name 3 things you will do to	

Section 5, your exercise habits

What are the main reasons for starting a fitness program? Please tick

General Conditioning	<input type="checkbox"/>	Weight/fat loss	<input type="checkbox"/>
Stress Management	<input type="checkbox"/>	Muscular strength	<input type="checkbox"/>
Aerobic Fitness	<input type="checkbox"/>	Flexibility	<input type="checkbox"/>
Enjoyment	<input type="checkbox"/>	Social	<input type="checkbox"/>
Improve self-esteem	<input type="checkbox"/>	Disease Prevention	<input type="checkbox"/>
Appearance	<input type="checkbox"/>	Other	<input type="checkbox"/>

Section 6

What would you identify as the main barriers preventing you from exercising in the future? Please tick

Procrastination	<input type="checkbox"/>	Lack of Motivation	<input type="checkbox"/>
No Time	<input type="checkbox"/>	Lack of Facilities	<input type="checkbox"/>
Injury	<input type="checkbox"/>	Lack of Ability/Fitness	<input type="checkbox"/>
Financial Cost	<input type="checkbox"/>	Lack of Knowledge	<input type="checkbox"/>
Family Responsibility	<input type="checkbox"/>	Medical Advice	<input type="checkbox"/>

Section 7, your nutritional needs

On a scale of 1-10 (1 being low, 10 being very high quality) how would you assess the quality of your diet?

1	2	3	4	5	6	7	8	9	10
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Do you follow any particular diet? Please tick appropriate box

Wholefood	<input type="checkbox"/>	Vegetarian & Fish	<input type="checkbox"/>
Vegan	<input type="checkbox"/>	Allergy elimination	<input type="checkbox"/>
Vegetarian	<input type="checkbox"/>	Other	<input type="checkbox"/>

Section 8, your lifestyle

How many units of alcohol do you drink in a typi-	

Please indicate the number smoked in a day:

1-9	10-19	20-39	40+
Do you want to give up smoking		Yes	

Section 9, your structural health

Do you have any of the following conditions? Please tick all boxes that apply

Osteoarthritis	<input type="checkbox"/>	Swollen joints	<input type="checkbox"/>
Rheumatoid Arthritis	<input type="checkbox"/>	Shoulder injury	<input type="checkbox"/>
Knee/thigh Injury	<input type="checkbox"/>	Head/neck injury	<input type="checkbox"/>
Back pain/injury	<input type="checkbox"/>	Hip/pelvis injury	<input type="checkbox"/>
Wrist/hand injury	<input type="checkbox"/>	Nerve damage	<input type="checkbox"/>
Ankle/foot injury	<input type="checkbox"/>	Bone Fracture	<input type="checkbox"/>

If you answered Yes, to any, please give details below

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Section 9 continued

Section 10, your Medical History

Is there a family history of any of the following medical conditions?

Heart Problems	<input type="checkbox"/>	Cancer	<input type="checkbox"/>
Early Menopause	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>		<input type="checkbox"/>

Please tick any of the following for which you have been diagnosed or treated by a physician or health professional:

Asthma	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	Heart Problems	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	Chest pains	<input type="checkbox"/>
Other, please give details	<input type="checkbox"/>		<input type="checkbox"/>

Please tick all taken within the last 6 months:

Blood Thinner	<input type="checkbox"/>	Diabetic medication	<input type="checkbox"/>
Epilepsy Medication	<input type="checkbox"/>	Diuretics	<input type="checkbox"/>
Beta Blockers	<input type="checkbox"/>	Other	<input type="checkbox"/>
If other please give details			

Section 10 continued

Please tick if you ever experience any of the following symptoms:

Ever get unusually short of breath with light exertion?	<input type="checkbox"/>
Regularly have unexplained pain in the abdomen, shoulder or arm?	<input type="checkbox"/>
Ever have pain, pressure, heaviness or tightness in the chest area?	<input type="checkbox"/>
Regularly get lower leg pain during walking that is relieved by rest?	<input type="checkbox"/>
Ever feel skips, palpitations or runs of fast beats in the chest?	<input type="checkbox"/>
Ever have severe dizzy spells or episodes of fainting	<input type="checkbox"/>
Please list any health problems you suffer from, not already mentioned,	

I can confirm to the best of my knowledge, that the information given is correct.

Name	
Signature	
Date	