CONFIDENTIAL

HEALTH, NUTRITION, AND FITNESS QUESTIONNAIRE

Date _____

Name _____ Age _____ Gender _____ Email

_____ Phone number _____

HEALTH GOALS

1. Please describe your major health, nutrition, and/or fitness goals:_____

_____

2. What are the two to three biggest barriers to achieving these goals?_____

_____

3. What are the two to three greatest strengths that will help you to achieve these goals?_____

_____

4. Please check the box that best describes how ready you are to make changes to your lifestyle to achieve these goals.

❑ Do not believe I need to change ❑ Will make changes soon
❑ Would like to intensify changes
❑ Would like to change, but don't think that I can
❑ Recently started to make changes (past 6 months) ❑ Made changes, but relapsed

5. On a scale of 1–10, how important is this change to you? _____

6. On a scale of 1–10, how confident are you that you will achieve this change? _____

MEDICAL INFORMATION

7. How would you describe your health? ❑ Excellent ❑ Good ❑ Fair ❑ Poor

8. Are you taking any prescription or over-the-counter medications or dietary herbs or supplements? ❑ Yes ❑ No

   If yes, please list the medications and state the reason for taking: _____

   _____

9. When was the last time you visited your physician? _____

10. Do I have permission to communicate with your physician? ❑ Yes ❑ No

    If yes, please state your physician's name and contact phone number. See HIPAA release form.

    _____

11. Do you have or has your doctor or another licensed healthcare professional told you that you have any of the following conditions?

- ❑ Allergies (specify: _____)
- ❑ Amenorrhea or absence of menstrual period >3 months
- ❑ Anemia
- ❑ Anxiety
- ❑ Arthritis
- ❑ Asthma
- ❑ Cancer
- ❑ Cardiovascular disease
- ❑ Celiac disease
- ❑ Chronic sinus condition
- ❑ Cigarette smoker
- ❑ Crohn's disease
- ❑ Depression
- ❑ Diabetes
- ❑ Disordered eating
- ❑ Intestinal problems
- ❑ Gastroesophageal reflux disease (GERD)
- ❑ High blood pressure/ hypertension
- ❑ High cholesterol
- ❑ Hyper/hypo-thyroidism
- ❑ Hypoglycemia
- ❑ Insomnia
- ❑ Intestinal problems
- ❑ Irritable bowel syndrome
- ❑ Osteoporosis
- ❑ Polycystic ovary disease
- ❑ Currently pregnant or <3 months postpartum
- ❑ Skin problems Describe:_____
- ❑ Surgeries Describe:_____
- ❑ Past injuries Describe:_____
- ❑ Describe any other health conditions you have, or for which you take medication:

12. Has anyone in your immediate family been diagnosed with any of the following? If yes, please describe.

	Relationship (e.g., father)	Age of diagnosis
❑ Heart disease		
❑ High cholesterol		
❑ High blood pressure		
❑ Cancer		
❑ Diabetes		
❑ Osteoporosis		

NUTRITION HISTORY

13. Have you ever followed a modified diet to manage a health condition? ❑ Yes ❑ No
    If yes, please describe: _____

14. Do you follow a specialized diet (low-carb, gluten-free, vegan, etc). ❑ Yes ❑ No
    If yes, please describe the diet and reasons for following: _____
    Was the diet prescribed by a physician? ❑ Yes ❑ No

15. Who purchases and prepares your food? _____

PHYSICAL-ACTIVITY HISTORY

16. Are you currently physically active? ❑ Yes ❑ No
    If yes, please describe: _____ minutes of cardiovascular activity, _____ times per week
    _____ minutes of strength or resistance training, _____ times per week
    _____ minutes of flexibility training, _____ times per week

17. Please list your favorite physical activities:_____

WEIGHT HISTORY

18. What would you like to do regarding your weight? ❑ Lose ❑ Maintain ❑ Gain
19. What was your lowest weight in the past five years ? _____ Your highest? _____
20. What is your current weight? _____ What is your height? _____

OTHER

Is there any other information that you think I should know? Please use this space._____

Thank you for your time and for sharing this information. It will be used to help develop a plan that will best meet your needs and help you to safely achieve your goals.