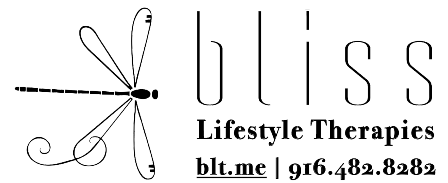
## Health & Fitness Information




Name:____________________________________________________________

Height:______________ DOB: ________________ Age:__________ Sex: M F

Address:________________________________________________________

Email:____________________________________________ Phone: ________________________________(best)

Current occupation: _________________________Hours/week? ___ Hobbies/Interests: _________________________

_______________________________________________________________________________________

**Circle one:**

No Yes Are you currently under the care of a physician? If yes, for what reason(s)________________________

No Yes Have you had any surgeries in the last 6 months?____________________________________________

No Yes Do you feel tired, run down, or out of energy? If yes, explain___________________________________

No Yes Are you currently on any medications? For...? (Please include OTC meds such as Ibuprofen)

__________________________________________________________________________________

No Yes Do you take any vitamin or herb supplements? Please list: ____________________________________

__________________________________________________________________________________

No Yes Have you exercised regularly in the last 6 months? How often? ____ x/wk. What type? _____________

No Yes Have you ever had a hard time attaining results or motivating yourself?

No Yes Will your significant other/family/friends be working out with you or supporting your goals?

No Yes Have you ever used a personal trainer before? ❏ 1-3 times ❏ 4+ times

No Yes Have you tried various weight loss programs in the past? Which ones?

___________________________________________________________________________________

If over weight, for how long? ______________ Are other family members overweight? ❏ No ❏ Yes

On a scale of 1 to 10, where 10 is the most important — How important is weight or size reduction to you? ____

**While trying to lose weight, have you ever experienced**: (check any) ❏ food cravings ❏ headaches ❏ fatigue ❏ lightheadedness ❏ water retention/swelling ❏ irritability ❏ other ______________________

**Do you**: smoke or vape? ❏ No ❏ Yes use recreational drugs? ❏ No ❏ Yes drink Alcohol? ❏ No ❏ Yes, ____ drinks/week. In the past 12 months, how many times have you been on antibiotics? ______

How stressed are you 0 to 10? (10 is as stressed as you can imagine) _____ How often? ❏ Daily ❏ Weekly ❏ Monthly

What are your primary health & fitness goals? ❏ Strength ❏ Endurance ❏ Energy ❏ Libido ❏ Other _______

On a scale of 1 - 10, how committed are you to achieving theses goals? _______ (10 = 100% committed)

What area of your body do you want to focus on?

❏ Abdomen ❏ hips/thighs ❏ Chest ❏ Arms ❏ Neck ❏ Cellulite ❏ All

What might have prevented you from reaching your health and fitness goals in the past?

❏ Time ❏ Money ❏ lack of support ❏ lack of motivation ❏ no plan ❏ Other ______________

How many times per week do you plan on exercising? ___________

***For Staff use:***

*PLEASE CONTINUE HEALTH INFO ON REVERSE —>*

| **Date** | **Weight** | **PH** | Fasting **Blood Sugar** | **BP: / P** |
|---|---|---|---|---|
| chest | waist | hips | Zinc | Other: |

Name: ____________________________________________

*(Continued from reverse...)*

How many times per day do you eat? ____ How often do you eat out? ❏ never ❏ rarely ❏ 3+ times/week ❏ daily

What is your caffeine intake? _____ cups daily/weekly/monthly. (circle one)

How much water do you drink daily? _______ liters/cups/ounces (circle)

**Do you currently have, or have a history of**:

❏ High Cholesterol
❏ High Blood pressure
❏ Heart disease
❏ Stroke
❏ Chest pain
❏ Diabetes
❏ Pre-diabetes
❏ Hypoglycemia
❏ TBI/Concussion
❏ Depression
❏ Liver problems
❏ Kidney problems
❏ Osteoporosis/penia

❏ Arthritis
❏ Spine/Disc issues
❏ Joint replacements
❏ Plantar fasciitis
❏ Scoliosis
❏ Rotator cuff tear
❏ Tennis Elbow
❏ Carpal tunnel
❏ Bladder prolapse
❏ SI joint dysfunction
❏ Balance issues
❏ Glaucoma
❏ Numbness

❏ Seizures
❏ Migraines
❏ Asthma
❏ Sleep apnea
❏ Chronic cough
❏ Shortness of breath
❏ Digestive disorder
____________________

❏ Cancer ______________

When? ______________

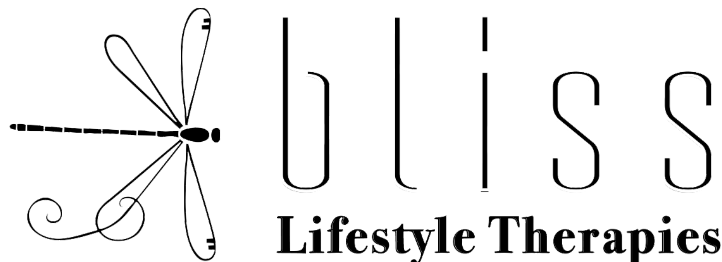
Please list any allergies: ____________________________________________

Are there any other health issues or concerns that may be relevant? ______________________

____________________________________________

Thank you very much for your time in helping us to better understand your health needs.

We look forward to helping you to achieve your health goals!




*Health is happiness! Get the health you need to live the life you want.*