

CLIENT HEALTH QUESTIONNAIRE

Please complete and return to Healthy Balance Fitness at least 2 days prior to your scheduled consultation.

All information received on this form will be treated as strictly confidential. Please fill out the forms **completely and accurately**. This information is essential to helping us develop a program that addresses your needs, goals and interests and is safe and effective.

Name: _____	Date of Birth	____/____/____	Age: _____
		M D Y	
Address: _____	Street	City	State Zip Code
Phone: _____	(h)	(o)	(fax)
Email address: _____			
Occupation: _____			
Emergency Contact: _____	Relationship: _____		
Phone Number: _____			
Physician's Name: _____	Physician's Phone: _____		
Physician's Address: _____	Street	City	State Zip Code

Please provide 24 hours notice if you need to cancel or reschedule your appointment.

Healthy Balance Fitness
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PAR-Q FORM

Please mark YES or No to the following:

YES NO

- Has your doctor ever said that you have a heart condition and recommended only medically supervised physical activity? _____
- Do you frequently have pains in your chest when you perform physical activity? _____
- Have you had chest pain when you were not doing physical activity? _____
- Do you lose your balance due to dizziness or do you ever lose consciousness? _____
- Do you have a bone, joint or any other health problem that causes you pain or limitations that must be addressed when developing an exercise program (i.e. diabetes, osteoporosis, high blood pressure, high cholesterol, arthritis, anorexia, bulimia, anemia, epilepsy, respiratory ailments, back problems, etc.)? _____
- Are you pregnant now or have given birth within the last 6 months? _____
- Have you had a recent surgery? _____

Do you take any medications, either prescription or non-prescription, on a regular basis? Yes/No

Please check which of the following conditions you have had or now have and list any medication you are currently taking for that condition. Also check medical conditions in your family (father, mother, brother(s), or sister(s)). Check all that apply.

Personal	Family	Medical Condition	Medication
<input type="checkbox"/>	<input type="checkbox"/>	Coronary heart disease, heart attack	_____
<input type="checkbox"/>	<input type="checkbox"/>	Angina	_____
<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure ____ mm Hg	_____
<input type="checkbox"/>	<input type="checkbox"/>	High cholesterol _____ mg/dl	_____
<input type="checkbox"/>	<input type="checkbox"/>	Peripheral vascular disease	_____
<input type="checkbox"/>	<input type="checkbox"/>	Phlebitis or emboli	_____
<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	_____
<input type="checkbox"/>	<input type="checkbox"/>	Stroke	_____
<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	_____
<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia	_____
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	_____
<input type="checkbox"/>	<input type="checkbox"/>	Bronchitis	_____
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes (specify type: _____)	_____
<input type="checkbox"/>	<input type="checkbox"/>	Thyroid conditions	_____
<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	_____
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	_____
<input type="checkbox"/>	<input type="checkbox"/>	Anemia (low iron)	_____
<input type="checkbox"/>	<input type="checkbox"/>	Bone fracture	_____
<input type="checkbox"/>	<input type="checkbox"/>	Depression	_____
<input type="checkbox"/>	<input type="checkbox"/>	High anxiety, phobias	_____
<input type="checkbox"/>	<input type="checkbox"/>	Eating disorders (anorexia, bulimia)	_____
<input type="checkbox"/>	<input type="checkbox"/>	Sleeping problems	_____

How does this medication affect your ability to exercise or achieve your fitness goals?

If you have marked YES to any of the above, please elaborate below:

Lifestyle Related Questions:

- 1) Do you smoke? YES NO If yes, how many? _____
- 2) Do you drink alcohol? YES NO If yes, how many glasses per week? _____
- 3) How many hours do you regularly sleep at night? _____
- 4) Describe your job: Sedentary Active Physically Demanding
- 5) Does your job require travel? YES NO
- 6) On a scale of 1-10, how would you rate your stress level (1=very low 10=very high)? _____
- 7) List your 3 biggest sources of stress:
a. _____ b. _____ c. _____
- 8) Is anyone in your family overweight? Mother Father Sibling Grandparent
- 9) Were you overweight as a child? YES NO If yes, at what age(s)? _____

Fitness History:

- 1) When were you in the best shape of your life? _____
- 2) Have you been exercising consistently for the past 3 months? YES NO
- 3) When did you first start thinking about getting in shape? _____
- 4) What if anything stopped you in the past? _____
- 5) On a scale of 1-10, how would you rate your present fitness level (1=Worst 10=Best)? _____

Nutrition Related Questions

- 1) On a scale of 1-10, how would you rate your Nutrition (1=very poor 10=excellent)? _____
- 2) How many times a day do you usually eat (including snacks)? _____
- 3) Do you skip meals? YES NO 4) Do you eat breakfast? YES NO
- 5) Do you eat late at night? Sometimes Often Never
- 6) What activities do you engage in while eating? (TV, reading etc) _____
- 7) How many glasses of water do you consume daily? _____
- 8) Do you feel drops in your energy levels throughout the day? YES NO If yes, when? _____
- 9) Do you know how many calories you eat per day? YES NO If yes, how many? _____
- 10) Are you currently or have you ever taken a multivitamin or any other food supplements? Y N
If yes, please list the supplements:

- 11) At work or school, do you usually: Eat out Bring food
- 12) How many times per week do you eat out? _____

13) Do you do your own grocery shopping? YES NO

14) Do you do your own cooking? YES NO

15) Besides hunger, what other reason(s) do you eat?

Boredom Social Stressed Tired Depressed Happy Nervous

16) Do you eat past the point of fullness? Often Sometimes Never

17) Do you eat foods high in fat and sugar? Often Sometimes Never

18) List 3 areas of your Nutrition you would like to improve:

a. _____ b. _____ c. _____

Exercise Related Questions: Skip to next section if you are presently inactive.

1) How often do you take part in physical exercise?

5-7x/week 3-4x/week 1-2x/week

2) If your participation is lower than you would like it to be, what are the reasons?

Lack of Interest Illness/Injury Lack of Time Other _____

3) How long have you been consistently physically active for? _____

4) What activities are you presently involved in?

Cardio &/or Sports	Frequency/Week	Average Length	Easy/Mod/Hard
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Strength Training	Frequency/Week	Average Length	Easy/Mod/Hard
_____	_____	_____	_____

List exercises: _____

Stretching	Frequency/Week	Average Length
_____	_____	_____

5) Please circle all the activities that interest you:

- | | | |
|-------------------------|---------------------------|---------------------|
| Aerobic Fitness Classes | Indoor Cycling | Snowshoeing |
| Baseball | Kayaking | Soccer |
| Basketball | Partner Training | Swimming |
| Boxing | Pilates | Tennis |
| Cross Country Skiing | Private Personal Training | Triathlon |
| Football | Racquetball | Volleyball |
| Golf | Rockclimbing | Walking |
| Group Personal Training | Running | Wallyball |
| Hiking | Skiing | White Water Rafting |
| Ice Skating | Snowboarding | Yoga |

Developing your Fitness Program:

1. Please circle how you prefer to exercise:

- a) INSIDE OUTSIDE COMBINATION
- b) LARGE GROUPS SMALL GROUPS ALONE COMBINATION
- c) MORNING AFTERNOON EVENING

2. Realistically, how often a week would you like to exercise? _____x/week

3. Realistically, how much time would you like to spend during each exercise session? _____

4. What are the best days during the week for you to commit to your exercise program?

 M T W T F S S

5. If you could design your own exercise program, what would an ideal training week look like to you? Please be specific. List your favorite activities, rest days, time spent etc.

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY

Goal Setting:

How can we help you? Please check that which applies.

- Lose Body Fat Develop Muscle Tone Rehabilitate an Injury Nutrition Education
 Start an Exercise Program Design a more advanced program Safety
 Sports Specific Training Increase Muscle Size Fun Motivation
 Other _____

In order to increase your chances of being successful at achieving your goals, a certain protocol should be followed. Please ensure all your goals are 'SMART'.

S= Specific (Provide details, how long, how much etc.)

M= Measurable (How will you measure whether you've reached your goals)

A= Attainable (Be realistic, set smaller goals)

R = Rewards-Based (Attach a reward to each goal)

T = Time Frame (Set specific dates for goals)

1. Please list in order of priority, the fitness goals you would like to achieve in the next 3-12 months?

a) _____

b) _____

c) _____

2. Where do you rate health in your life? Low priority Medium Priority High priority

3. How committed are you to achieving your fitness goals? Very Semi Not very

4. What do you think the most important thing we can do to help you achieve your fitness goals?

5. Outline what you feel are the obstacles or your potential actions, behaviors or activities that could impede your progress towards accomplishing your goals (i.e. not training consistently, upcoming vacation, busy season at work, not following the program, allowing other responsibilities to become a priority over exercise etc.).

6. Outline 3 methods that you plan to use to overcome these obstacles:

a. _____ b. _____ c. _____

Miscellaneous Questions:

1. How did you hear about us? Please check that which applies.

- Brochure Word of Mouth Flyer Newsletter Website
 Health Professional (Doctor, Dietitian, Physical Therapist, etc) Meal Delivery Program WRS
 Other _____

2. If you were referred to us, who told you about our services?

3. Why did you choose to work with Healthy Balance Fitness instead of another organization? Please check that which applies.

- Location Personal Trainers Cost Customer Service Word of Mouth Programs
 Other _____

4. How far do you live from our facility? _____ miles

5. Which newspaper(s) do you read? _____

6. Which magazine(s) do you read? _____