

H.E.A.L.T.H

Information Form

Full Name: _____ Preferred email address _____

Cell Number: _____ DOB ____/____/____ Gender: Male Female

Occupation: _____

Name of Emergency Contact: _____ Best Phone Number: _____

Primary Care Doctor: _____ Primary Care phone number: _____

Current weight _____ lbs Goal weight _____ lbs Ht: _____ ft _____ in

How would you describe your overall, general Health: Excellent Good Average Fair Poor

Have you ever been diagnosed with any of the following:

| | Yes or No | | Yes or No |
|--|-----------|--|-----------|
| Type 1 DM | | Autoimmune Disease | |
| Type 2 DM | | HYPOTHYroidism | |
| Healing Problems/open wounds | | HYPERthyroidism | |
| Multiple Sclerosis | | Osteoporosis or Osteopenia | |
| Neuropathy | | Osteoarthritis | |
| Fibromyalgia | | Rheumatoid Arthritis | |
| Other soft tissue disorder | | PCOS/ Endometriosis | |
| Hearing Impairment | | Infertility or other reproductive conditions | |
| Vision Impairment | | Uterine or Bladder Prolapse | |
| Developmental or Growth Irregularities | | Kidney Disease, Kidney Stones or Urinary Conditions | |
| Asthma | | Allergies | |
| Emphysema/COPD | | Cancer | |
| Seizures/Epilepsy | | Dementia | |
| Stroke/TIA | | Depression | |
| Vascular Disease | | Anxiety | |
| HYPERTension | | Mental illness | |
| HYPOTension | | Drug/Alcohol Dependency | |
| Dizziness or Vertigo | | Artificial Joints | |
| Pacemaker or Stent | | Chronic Constipation | |
| Angina or Arrhythmia | | Ulcerative Colitis | |
| Heart Disease | | Inflammatory Bowel Disease or Irritable Bowel Syndrome | |
| Celiac Disease | | Crohn's Disease | |
| Obesity | | Gait Imbalance | |
| Gastric or Peptic Ulcer Disease | | Gerd, Reflux/Heart Burn | |
| Anemia | | Gout | |
| High Cholesterol | | Cerebral Palsy | |
| Muscular Dystrophy | | Gastroparesis | |
| Heart Attack | | Migraines | |
| Sleep Apnea | | | |

Next 4 questions Females only:

Are you currently pregnant? Yes or No, How many weeks are you? _____

Are you currently on hormone replacement therapy, TRT Pellets? Yes_____ NO___ If yes, what are you taking

Are you: Perimenopausal_____, post-menopausal_____, neither still menstruating_____

Do you experience menopausal symptoms?

For any marked conditions above please share further details:

Are there any other acute or chronic conditions you experience:

Are you currently under the supervision of a physician for reason outside of regular PCP visits? If yes, please explain

Please list any past injuries, surgeries or hospitalizations

Please list any names of the current medication or supplements you are taking

Have you needed to have or currently taking any regular Injections of Steroid Medication (prednisone, sol Medrol)?

If yes, what are you taking? _____

Have you or are you taking any acid blocking drugs ?

Have you or are you taking any GLP 1 medications, such as Ozempic, semaglutide, wegovy, etc Yes _____ NO___

If yes, which one are you/have you taken_____, what was your results _____

Check mark which of the following areas are you interested in gaining improvements in?

| | | | | |
|--|--|--|---|--|
| Strength Training | | | Injury Prevention | |
| Mobility | | | Injury Rehabilitation | |
| Gait Balance | | | Sport Specific Conditioning | |
| Pain Management | | | Weight Loss | |
| Healthy Weight Gain | | | Weight Maintenance | |
| Learning more about Nutrition for Health | | | Learning more about Exercise for Health | |

Do you have a fitness watch or tracer (ex: Appel watch, garmin, polar)? Yes_____ No_____ if yes, what kind_____

How would you rate your exercise proficiency? Highly proficient Some exercise No experience Unsure

On a scale of 1-10, with 10 being highly motivated, how would you rate your current level of motivation as it related to your fitness and wellness goals? _____

Physical Activity Readiness Questionnaire

Regular physical activity is fun and healthy, and increasingly more people are becoming more active every day. Being more active is very safe for most people. However, some people should check with their doctor before they start becoming much more physically active. If you are planning to increase your activity level, start by answering the seven questions. If you are between the ages of 15 and 69, the Par Q will tell you if you should check with your doctor before you start. IF you are over 69 years of age and you are not used to being very active, check with your doctor before beginning new exercise regime

| Question | Yes | NO |
|---|-----|----|
| Has your doctor ever said that you have a heart or cardiovascular condition and that you should only do physical activity recommended by a doctor | | |
| Do you feel pain in your chest when you do physical activity | | |
| In the past month, have you had chest pain when you were NOT doing physical activity | | |
| Do you lose your balance because of dizziness or do you ever lose consciousness? | | |
| Do you have a bone or joint problem that could be made worse by a change in your physical activity? | | |
| Is you doctor currently prescribing medication for your blood pressure or heart condition? | | |
| Do you know of any other health reason why you should enter into physical activity cautiously | | |

- How would you rate your diet? Excellent____ Good____ Fair____ Poor_____
- My nutrition knowledge is: Very good____ Good____ Average____ Not so good____ I want to learn more____
- Have you ever had a consultation with a dietitian or nutritionist? Yes____ No_____
- Have you ever tried structured programs to lose weight? Yes____ No____ Were you successful? Yes, ____ No____ If yes, how much weight did you lose? _____ How long did you keep it off? _____
- Do you have any food allergies? Yes____ No____ If yes, what are you allergic to? _____
- Do you have any food intolerances or strong dislikes? Yes____ No____ If yes, to what specific foods? _____

7. How many meals do you eat per day?

one meal _____ one to two meals _____
two meals _____ two to three meals _____
three meals _____ three or more meals _____

8. If you skip meals what meal(s) do you usually skip: breakfast ____ lunch ____ dinner ____

9. How many days a week do you skip this meal _____

10. I eat out for:

Breakfast: rarely ____ sometimes ____ often ____ daily ____

Lunch: rarely ____ sometimes ____ often ____ daily ____

Dinner: rarely ____ sometimes ____ often ____ daily ____

11. Are your meals? large portion _____ extra-large portions _____ high fat ____ high carbohydrate _____
high sugar _____

12. How often do you snack? a.m. snack _____ p.m. snack _____ evening snack _____
snack between all meals _____ grazing on food throughout the day _____

13. What beverages do you drink (please mark how many ounces you drink of each daily)

Water _____ whole milk _____ Sport Drinks _____
Diet soda _____ Regular soda _____ Other _____
Regular coffee _____ Decaf coffee _____
Regular tea _____ Decaf tea _____
2% milk _____ 1% milk _____
skim milk _____ juice _____
sweet tea _____ unsweetened tea _____

14. How often do you eat fast food or go to a restaurant?

0-1/month _____ 2-3/month _____ 1-2/week _____ 3-4/week _____ 5+/week _____

15. How often do you drink alcohol?

0-1/month _____ 2-3/month _____ 1-2/week _____ 3-4/week _____ 5+/week _____

16. When you drink, on average, how many servings of alcohol do you drink in one sitting (1 serving = 12 oz beer, 5 oz wine, 1 oz liquor)? serving(s) If yes what type how much and how often.

17. Do you smoke? ____yes, ____no if quit, when _____

18. How many days a week do you eat/drink:

_____ Fish/seafood _____ Processed Sugar (cookies, ice cream, etc.)
_____ Beans/Lentils _____ Nuts/Seeds
_____ Berries _____ All other fruit
_____ Cruciferous Vegetables (broccoli, cauliflower, brussels sprouts)
_____ Dark Leafy Green Vegetables (spinach, kale, arugula)
_____ Fast Food _____ Processed meat (bacon, sausage etc.)
_____ Chewing Gum

19. What do you typically eat for breakfast:

20. What do you typically eat for lunch:

21. What do you typically eat for dinner?

22. What do you typically snack on?

23. From the list below what triggers you to eat: availability of food ___ loneliness ___ habit ___ lack of appetite awareness ___ external cues ___ stress ___ social situations ___ sadness ___ anger ___ depression ___ boredom ___ hunger ___ self-reward ___ comfort ___ PMS ___ anxiety Other _____

24. Are you currently following a special diet (e.g., low fat, low salt)? Yes, ___ No ___

If yes, what diet are you on? _____

25. On a scale of 1-10, how likely are you to make dietary changes? _____

26. On a scale of 1-10, with 10 being highly stressed, how would you rate your average daily stress level?

_____ 27. Where does stress originate (work, school, family etc.) _____

28. How many hours of sleep do you get a night? _____

29. Do you sleep well? Yes ___ No ___

30. On a scale of 1-5 please indicate your readiness/willingness to do the following

| Modify your diet | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|
| Keep record of your food and drink intake | | | | | |
| Modify your lifestyle: (ex: work demands sleep habits, physical activity) | | | | | |
| Engage in regular exercise/physical activity | | | | | |

31. What helps you stay motivated:

Accountability partner _____ Weekly check in with people _____ Motivational books to read _____ Motivational sayings _____ Having a community of other individuals doing the same thing to meet with

What are your top 2-3 health goals

Consent and Agreement to Participate in Health, Fitness, and Nutrition Program

I have been informed that I will perform various physical tests and activities designed to evaluate and positively enhance my health, fitness and wellness status. I certify that I am of sound cognizance and that I have provided complete and accurate responses to questions herein this intake form. I recognize risks associated with physical exercises do exist and that any withholding of information regarding my health history could lead to possibly injury during these exercise and procedures. I agree to disclose any changes in my health status as these changes could lead to possible injury during these exercises and procedures. I agree to disclose any changes in my health status as these changes arise prior to any future sessions. **I understand that I am welcome to cease participation in physical exercise or training at any time without penalty.** (QUESTION HERE ABOUT THIS WITH PROGRAM/ or should say with training and exercise testing)

I understand that physical exercise training conducted with my personal trainer/strength and conditioning coach is for general wellness purpose and is not a substitute for medical examination, diagnosis or treatment. I understand that the trainer/coach reserves the right to determine the appropriate exercise and degree of intensity for each client.

Signature _____

Date _____