

3 WAY FITNESS
LIFESTYLE QUESTIONNAIRE

This questionnaire covers several areas which will enable me to provide you with the best fitness training and coaching possible. Please complete each portion thoroughly and thoughtfully. In answering the questions, please respond in a way that describes your situation most of the time.

PERSONAL INFORMATION

Date: _____

Name: _____

Email: _____

Address: _____

(street)

(city, state)

(zip code)

Primary Phone: Cell _____ Home _____

Age: _____

Date of Birth: _____

Weight: _____

Height: _____

What are your desired fitness goals?

Weight: _____ Waist Size: _____ Dress or Pant Size: _____

Other: _____

DAILY LIFESTYLE

Current Occupation: _____

Does your occupation require extended periods of sitting? Yes or No

Do you use repetitive movements for an extended time? Yes or No

If yes, please explain _____

Does your occupation cause you stress or mental anxiety? Yes or No

Do you exercise (cardio, yoga, resistance training, etc.)? Yes or No

If yes, how often? _____

Do you participate in any recreational activities (golf, tennis, basketball, etc.)?

If yes, please explain _____

Do you have any hobbies? Yes or No

If yes, please explain _____

WEIGHT LOSS ASSESSMENT

What was your heaviest weight? _____ lbs. When?

What factors do you think caused you to become your heaviest?

How many weight loss programs have you begun in the past? (Including any attempts, however short). Circle one.

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16+

If you have attempted to lose weight in the past, how much weight did you lose during your most successful attempt? _____ lbs.

Using the scale below, please rate the extent to which the following factors make it **difficult** for you to lose weight.

1= not at all 2= a little 3= somewhat 4= quite a bit 5= very much

- _____ Your biology (metabolic rate, fat cells, injuries, etc.)
 _____ Your ability to handle stress and other problems in your life
 _____ Your family or culture
 _____ Your eating and exercising habits

In the past, which of the following techniques helped you to avoid overeating?
 (Check all that apply.)

- _____ Drinking water, coffee, or other no-calorie liquids
 _____ Eating celery or other low calorie vegetables
 _____ Physical exercise
 _____ Leaving the tempting situation
 _____ Waiting for the urge to pass
 _____ Seeking help from others
 _____ Thinking of the positive health benefits of losing weight
 _____ Thinking of the positive psychological benefits (e.g., improved self-confidence) of losing weight
 _____ Thinking of the negative health consequences of gaining weight
 _____ Thinking of the negative psychological consequences of gaining weight (e.g., loss of self-esteem, increased self-consciousness)
 _____ Chastising yourself for being weak, etc.
 _____ Others? Please be specific. _____

Do you have a spouse, partner, friend or relative who would be willing to cooperate with your fitness efforts? (Note: This person must be someone who will hold you accountable to your fitness goals.)

_____ Yes _____ No

HEALTH STATUS

Have you ever had any pain or injuries (ankle, knee, hip, back, shoulder etc.) ?

If yes, please explain _____

Please describe your experience with any recent and/or significant medical problems, procedures, and accidents.

Has a medical doctor ever diagnosed you with a chronic disease, such as coronary heart/ artery disease, high blood pressure or cholesterol, or diabetes?

If yes, please explain _____

Are you currently taking any medications? If yes, what are they for?

Do you have any health problems that would prevent you from participating in a moderate or intense exercise program?

_____ Yes _____ No

If yes, please explain _____