Your Health Solution

Name:_____

Height:_____

Weight:_____

Birthdate:_____

Occupation:_____

Email:_____

Address:_____

Phone Number:_____

Family Physician:_____

- Do you have any problems with bones, joints or muscles that may be aggravated by exercise? Yes No
- Joint(s) affected - _____
- _____
- Do you smoke? Yes No If yes, how many per day? _____
- Are you interested in quitting? Yes No

- Are you currently experiencing any of the following:

    - Pain/discomfort in the chest or surrounding areas that occurs when you engage in physical activity

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- Shortness of breath
- Dizziness or fainting
- Swelling of the ankles
- Palpitations (irregularity or racing the heart on more than 1 occasion)
- Pain in the legs that causes you to stop walking
- Diagnosis of a heart murmur

- Are you currently taking any medications? Yes No
  If yes, please list type and dosage
  _____
- _____

- Describe your current physical activity or exercise program.
  - ➢ What kind of exercise _____
  - ➢ How often _____ days per week
  - ➢ Intensity - Low Medium High – low being able to have a conversation to high being slightly breathless

- How many hours do you regularly sleep at night? _____

- Describe your job: Sedentary Active Physically Demanding

- Describe a typical work day_____
- _____
- _____

- On a scale of 1-10, how would you rate your stress level (1=very low, 10=very high) _____

- List your 3 biggest sources of stress:

  a. _____ b. _____ c. _____

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- How are you currently dealing with these stressors? _____

  _____

- When were you in the best shape of your life? _____

_____

- What type of activity were you participating in at that time?

  _____

- On a scale of 1-10, how would you rate your present fitness level (1=worst, 10=best) _____

- On a scale of 1 –10, how would you rate your Nutrition (1=very poor, 10=excellent) _____

- Do you skip meals? Yes No – if yes, why are you skipping meals?

  _____

- Do you eat breakfast? Yes No – if no, why? _____

  _____

- How many glasses (8 ounces – 1 cup) of water do you consume daily? ____

- Do you feel drops in your energy levels throughout the day? Yes No

  If yes, when? _____

  What do you think are contributing factors to your drop in energy?

  _____

  _____

- List 3 areas of your nutrition you would like to improve:

a. _____ b. _____ c._____

- Where do you rate health in your life?
  Low priority Medium priority High priority

- How committed are you to achieving your fitness goals? _____

_____

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