Scott Sanders

Personal Trainer / Massage Therapist / Nutritional Advisor

Confidential Health and Lifestyle Questionnaire

Name .....
Address .....
Home telephone .....
Work telephone .....
Email .....
Occupation .....
Date of birth .....

Doctor's name .....
Address .....
Telephone .....

Emergency contact .....
Relationship .....
Home telephone .....
Work telephone .....

Health Questionnaire

Have you, or do you suffer from any of the following?

☐ Asthma	☐ Constipation	☐ Rheumatic fever
☐ Angina	☐ Diabetes	☐ High cholesterol
☐ High blood pressure	☐ Frequent colds	☐ Palpitations
☐ Low blood pressure	☐ Dizziness/fainting	☐ Headaches
☐ Epilepsy	☐ Heart disease	☐ Migraines
☐ Arthritis	☐ Shortness of breath	☐ Joint pains

Please provide details where applicable. .....

Have any of your first-degree relatives experienced the following conditions?

Heart attack ☐ Heart operation ☐ Congenital heart disease ☐ High cholesterol ☐

Have you ever had surgery? Yes ☐ No ☐
If yes, give details.

Please list any injuries you've had in the past, i.e., broken bones, sprains, etc.

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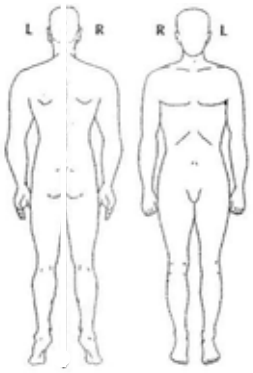
Do you have tension or soreness in a specific area? *If yes, give details.*	Yes ☐	No ☐
Do you experience numbness, tingling or stabbing pains anywhere? *If yes, give details.*	Yes ☐	No ☐
Are you sensitive to touch/pressure in any area? *If yes, give details.*	Yes ☐	No ☐
Do you experience stiff, swollen or painful joints? *If yes, give details.*	Yes ☐	No ☐
What is your "chief complaint"?		
Date of onset and duration		
What incident do you feel may have caused the problem?		
Treatment to date		
Previous diagnoses		
Does your "chief complaint" affect you on a day-to-day basis? *If yes, give details.*	Yes ☐	No ☐
Are the symptoms brought on by certain activities? *If yes, give details.*	Yes ☐	No ☐
Do specific activities or positions alleviate your symptoms? *If yes, give details.*	Yes ☐	No ☐
When is the pain worse?		
Do you experience fatigue or lack of energy? *If yes, give details.*	Yes ☐	No ☐
What is your current weight?		
Have you had any of the following: physical therapy, osteopathy, massage therapy, other? *If yes, please elaborate.*	Yes ☐	No ☐
Please list any medications you are currently taking.		

Indicate on the diagrams where you have been experiencing pain.



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Lifestyle Questionnaire

Occupation; please explain your position along with the physical and mental responsibilities involved.

Do you have an ergonomically set up desk/workstation? Yes ☐ No ☐

How many hours do you spend in front of a computer?

How much time do you spend in a seated position?

On a scale of 1-10 (1=not active, 10=very active), please circle how active you are on a daily basis.

1 2 3 4 5 6 7 8 9 10

How often do you take part in physical exercise?

7+ times/week 5-6 times/week 3-4 times/week 1-2 times/week

How long have you been consistently physically active for?

What activities are you presently involved in?

Cardio/Sports	**Frequency/week**	**Average length**	**Easy/Moderate/Hard**

Strength Training	**Frequency/week**	**Average length**	**Easy/Moderate/Hard**

Stretching	**Frequency/week**	**Average length**

Please check all the activities that interest you:

☐ Aerobic fitness class	☐ Kayaking	☐ Soccer
☐ Baseball	☐ Partner training	☐ Swimming
☐ Basketball	☐ Pilates	☐ Tennis
☐ Boxing	☐ Private personal training	☐ Triathlon
☐ Football	☐ Racquetball	☐ Volleyball
☐ Golf	☐ Rock climbing	☐ Walking
☐ Group personal training	☐ Running	☐ White water rafting
☐ Hiking	☐ Skiing	☐ Yoga
☐ Ice skating	☐ Snowboarding	☐ Other, specify below
☐ Indoor cycling	☐ Snowshoeing	

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How many hours sleep do you get everyday?

Do you consider yourself to be under stress? Yes ☐ No ☐
If yes, give details.

Do you smoke? Yes ☐ No ☐
If yes, how many per day.

Do you drink alcohol?
If yes, how many units per week.

Diet Questionnaire

Do you follow, or have you recently followed, any specific dietary intake plan? Yes ☐ No ☐
If yes, give details

In general, how do feel about your nutritional habits?

Daily Dietary Intake

No. of cups of coffee		Amount of sugar	
No. of cups of tea		Chocolates	
Glasses of coke/soda		Sweets	
Glasses of milk		Alcohol	
Glasses of water		Portions of fruit	
Bread, pasta		Portions of vegetables	

Food Diary Snapshot

Breakfast		Time
Snack		Time
Lunch		Time
Snack		Time
Dinner		Time
Snack		Time

Goal Questionnaire

Please list THREE goals in order of importance:

1.
2.
3.

Where are you now in relation to your goals?

1.
2.
3.

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What is the biggest challenge you must overcome to attain your goal?

☐ Lack of interest/motivation	☐ Procrastination	☐ Lack of time
☐ Injury	☐ Lack of ability/fitness	☐ Lack of facilities
☐ Financial cost	☐ Family responsibility	☐ Medical Advice
☐ Low self-esteem	☐ Other, specify	

On a scale of 1-10 (1=not committed, 10=very committed), please rate how committed you are to your goals.

1 2 3 4 5 6 7 8 9 10

List three tasks you can do to pave the path toward total achievement.

1. _____
2. _____
3. _____

Have you ever had a personal trainer? Yes ☐ No ☐

If yes, give details of when and for how long

How did you find out about my services?

☐ Brochure	☐ Yellow pages	☐ Magazine article
☐ Newspaper	☐ Website	☐ Newsletter
☐ Referral, specify		

Why did you choose to train with my organisation?

☐ Word of mouth	☐ Quality of programs	☐ Personal trainers
☐ Location	☐ Cost	☐ Credibility
☐ Other, specify		

All the information on this form is correct and to the best of my knowledge. I have sought and followed any necessary medical advice.

Signature _____

Print name _____

Date _____

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