**Lifestyle and Health History Nutritional Guidance Questionnaire**

**CLIENT PERSONAL INFORMATION**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

Age: \_\_\_\_\_\_\_\_\_\_\_\_\_ Gender: \_\_\_\_\_\_\_\_\_\_\_\_\_ Height: \_\_\_\_\_\_\_\_\_\_\_\_\_ Weight: \_\_\_\_\_\_\_\_\_\_\_\_\_

Physician Name and Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact Name and Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EXERCISE What exercise activities do you currently take part in (e.g., running, weightlifting, group exercise, etc.)?

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How many days per week do you get at least 60 minutes of moderate-intensity exercise? \_\_\_\_\_\_\_\_\_

On a scale of 0 to 10, how important are the following fitness goals to you?

Weight loss: \_\_\_\_\_ Muscle gain: \_\_\_\_\_\_Sports performance: \_\_\_\_\_\_Health improvement: \_\_\_\_\_\_\_

What is your goal weight? \_\_\_\_\_\_\_\_\_\_\_

Are you currently following any kind of diet? If so, what diet and for what reason(s)?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

On a scale of 0 to 10, how effectively are you able to control your temptations for junk food? \_\_\_\_\_\_\_

How many alcoholic drinks do you consume per week? \_\_\_\_\_\_\_\_\_\_

Do you consume caffeinated beverages such as coffee, tea, soda, and/or energy drinks? How many per week?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**LIFESTYLE**

Do you feel like you get enough sleep and wake up feeling rested each day? \_\_\_\_\_\_\_\_

On a scale of 0 to 10, how would you rate your average level of stress? \_\_\_\_\_\_\_\_\_\_

What techniques do you currently use to manage your stress levels?

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Do you smoke tobacco or use a vaporizer alternative?

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**OCCUPATION**

What is your occupation?

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Does your occupation require extended periods of sitting? (If YES, please explain.)

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**MEDICAL**

(Check all that apply)

Diabetes (type 1) \_\_\_ Anemia or low ion \_\_\_ Crohns/IBD \_\_\_

Diabetes (type 2) \_\_\_ Low zinc levels \_\_\_ Celiac disease \_\_\_

Kidney disease \_\_\_ Low vitamin B12\_\_\_ Thyroid disease \_\_\_

Diarrhea \_\_\_ Low bone density \_\_\_ Cancer \_\_\_

Nausea \_\_\_ Acid reflux/heartburn \_\_\_ High blood pressure \_\_\_

Vomiting \_\_\_ Ulcers \_\_\_ High cholesterol \_\_\_

Constipation \_\_\_ IBS \_\_\_ Heart disease

Allergies:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family medical history:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you take any over the counter or prescription vitamins?

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Have you ever been diagnosed with an eating disorder? (If yes, please explain)

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Do you have any other medical conditions not listed in the questionnaire?

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Lifestyle and Health History Questionnaire Additional Notes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Delay becoming active if:**

* **You are pregnant – talk to your health care practitioner, your physician, or a qualified professional before seeking nutrition guidance**
* **Your health changes – talk to your doctor or qualified professional before continuing with any nutrition program**

**You are encouraged to make a photocopy of this form.**

**The trainer assumes no liability for persons who seek nutrition guidance. If in doubt after completing the questionnaire, consult your doctor prior to continuing.**

**Participant Declaration**

* All persons who have completed the health history form, please read and sign the declaration below.
* If you are less than the legal age required for consent or require the assent of a care provider, your parent, guardian, or care provider must also sign this form.

I, the undersigned, have read, understood to my full satisfaction and completed this questionnaire. I acknowledge that this physical activity clearance is valid for a maximum of 12 months from the date it is completed and becomes invalid if my condition changes. I also acknowledge that the community/fitness center/trainer may retain a copy of this form for records. In these instances, it will maintain the confidentiality of the same, complying with the applicable law.

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of parent/guardian/care provider \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_