CORE FITNESS
BY NAZ

Core Fitness By Naz

Lifestyle and Health History Questionnaire CLIENT PERSONAL INFORMATION

Nutritional Guidance

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.)?

_____

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? _____

When would like to reach your goal weight by? _____

Are you currently following any kind of diet? Do you eat zabiha only?

_____

Do you have any dietary restrictions?

_____

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?

Do you partake in any recreational activities (golf, tennis, etc.)

_____

Do you smoke tobacco or use a vaporizer alternative?

_____

OCCUPATION

What is your occupation?

_____

MEDICAL

(Check all that apply)

Diabetes (type 1) ☐	Anemia or low iron ☐	Crohns/IBD ☐
Diabetes (type 2) ☐	Low zinc levels ☐	Celiac disease ☐
Kidney disease ☐	Depression ☐	Thyroid disease ☐
Back problems ☐	Knee issues ☐	Cancer ☐
Nausea ☐	Arthritis/osteoporosis ☐	High blood pressure ☐
Nursing ☐	Pregnant ☐	High cholesterol ☐
Constipation ☐	IBS ☐	Heart disease ☐
Eating disorder ☐	Spinal cord injuries ☐	Respiratory disease ☐

MEDICAL

Please list out any past musculoskeletal injuries:

_____

Please list out any past surgeries:

_____

If you have experienced injuries or surgeries, were they properly rehabilitated, and did you receive clearance from a doctor to return to physical activity?

_____

Do you have any medical conditions not listed in this form?

_____

Do you currently have (or have had in the past 12 months) a bone, joint, soft tissue (muscle, ligament, or tendon) problem that could be made worse by becoming more physically active?

Has your doctor ever stated you should only do medically supervised physical activity?

_____

List equipment you have access to at home or where you will be completing exercise program

Stretching/balance (ex. Self myofascial roller, balance ball, etc)

_____

Cardio (ex. Treadmill, stationary bike, rower, jump rope, etc)

_____

Strength (ex. Dumbbells, barbell, kettle bells, bands, medicine balls, etc) Please list dumbbell weights:

_____

How many days per week are you able to work out? _____ Days Duration _____ Minutes per day

_____

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 _____