CLIENT HEALTH QUESTIONNAIRE

Please complete and return to Healthy Balance Fitness at least 2 days prior to your scheduled consultation.

All information received on this form will be treated as strictly confidential. Please fill out the forms ***completely and accurately***. This information is essential to helping us develop a program that addresses your needs, goals and interests and is safe and effective.

Name: _____ Date of Birth____/____/____ Age:_____
M D Y

Address: _____
Street City State Zip Code

Phone: _____(h) _____(o) _____(fax)

Email address: _____

Occupation:_____

Emergency Contact: _____ Relationship: _____

Phone Number:
_____

Physician's Name: _____ Physician's Phone:_____

Physician's Address: _____
Street City State Zip Code

Please provide 24 hours notice if you need to cancel or reschedule your appointment.

Healthy Balance Fitness
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PAR-Q FORM

Please mark YES or No to the following:	YES	NO
Has your doctor ever said that you have a heart condition and recommended only medically supervised physical activity?	____	____
Do you frequently have pains in your chest when you perform physical activity?	____	____
Have you had chest pain when you were not doing physical activity?	____	____
Do you lose your balance due to dizziness or do you ever lose consciousness?	____	____
Do you have a bone, joint or any other health problem that causes you pain or limitations that must be addressed when developing an exercise program (i.e. diabetes, osteoporosis, high blood pressure, high cholesterol, arthritis, anorexia, bulimia, anemia, epilepsy, respiratory ailments, back problems, etc.)?	____	____
Are you pregnant now or have given birth within the last 6 months?	____	____
Have you had a recent surgery?	____	____

Do you take any medications, either prescription or non-prescription, on a regular basis? Yes/No

Please check which of the following conditions you have had or now have and list any medication you are currently taking for that condition. Also check medical conditions in your family (father, mother, brother(s), or sister(s)). Check all that apply.

Personal	Family	Medical Condition	Medication
❑	❑	Coronary heart disease, heart attack	_____
❑	❑	Angina	_____
❑	❑	High blood pressure ___ mm Hg	_____
❑	❑	High cholesterol _____ mg/dl	_____
❑	❑	Peripheral vascular disease	_____
❑	❑	Phlebitis or emboli	_____
❑	❑	Epilepsy	_____
❑	❑	Stroke	_____
❑	❑	Emphysema	_____
❑	❑	Pneumonia	_____
❑	❑	Asthma	_____
❑	❑	Bronchitis	_____
❑	❑	Diabetes (specify type: _____)	_____
❑	❑	Thyroid conditions	_____
❑	❑	Osteoporosis	_____
❑	❑	Arthritis	_____
❑	❑	Anemia (low iron)	_____
❑	❑	Bone fracture	_____
❑	❑	Depression	_____
❑	❑	High anxiety, phobias	_____
❑	❑	Eating disorders (anorexia, bulimia)	_____
❑	❑	Sleeping problems	_____

How does this medication affect your ability to exercise or achieve your fitness goals?

_____
_

If you have marked YES to any of the above, please elaborate below:

_____

Lifestyle Related Questions:

1) Do you smoke? YES NO If yes, how many?_____

2) Do you drink alcohol? YES NO If yes, how many glasses per week?_____

3) How many hours do you regularly sleep at night? _____

4) Describe your job: ❍ Sedentary ❍ Active ❍ Physically Demanding

5) Does your job require travel? YES NO

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

7) List your 3 biggest sources of stress:
a. _____ b. _____ c._____

8) Is anyone in your family overweight? ❍Mother ❍Father ❍Sibling ❍Grandparent

9) Were you overweight as a child? YES NO If yes, at what age(s)?_____

Fitness History:

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

2) Have you been exercising consistently for the past 3 months? YES NO

3) When did you first start thinking about getting in shape? _____

4) What if anything stopped you in the past? _____

5) On a scale of 1-10, how would you rate your present fitness level (1=Worst 10=Best)?_____

Nutrition Related Questions

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

2) How many times a day do you usually eat (including snacks)? _____

3) Do you skip meals? YES NO 4) Do you eat breakfast? YES NO

5) Do you eat late at night? ❍ Sometimes ❍ Often ❍ Never

6) What activities do you engage in while eating? (TV, reading etc) _____

7) How many glasses of water do you consume daily? _____

8) Do you feel drops in your energy levels throughout the day? YES NO If yes, when?_____

9) Do you know how many calories you eat per day? YES NO If yes, how many?_____

10) Are you currently or have you ever taken a multivitamin or any other food supplements? Y N
If yes, please list the supplements:
_____
_____

11) At work or school, do you usually: ❍ Eat out ❍ Bring food

12) How many times per week do you eat out? _____

13) Do you do your own grocery shopping? YES NO

14) Do you do your own cooking? YES NO

15) Besides hunger, what other reason(s) do you eat?

❍Boredom ❍ Social ❍ Stressed ❍ Tired ❍ Depressed ❍ Happy ❍ Nervous

16) Do you eat past the point of fullness? ❍ Often ❍ Sometimes ❍ Never

17) Do you eat foods high in fat and sugar? ❍ Often ❍ Sometimes ❍ Never

18) List 3 areas of your Nutrition you would like to improve:

a._____ b._____ c._____

Exercise Related Questions: Skip to next section if you are presently inactive.

1) How often do you take part in physical exercise?

5-7x/week 3-4x/week 1-2x/week

2) If your participation is lower than you would like it to be, what are the reasons?

Lack of Interest Illness/Injury Lack of Time Other_____

3) How long have you been consistently physically active for? _____

4) What activities are you presently involved in?

Cardio &/or Sports	Frequency/Week	Average Length	Easy/Mod/Hard
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
Strength Training	Frequency/Week	Average Length	Easy/Mod/Hard
	_____	_____	_____
List exercises:_____			
_____			
Stretching	Frequency/Week	Average Length	
	_____	_____	

5) Please circle all the activities that interest you:

Aerobic Fitness Classes	Indoor Cycling	Snowshoeing
Baseball	Kayaking	Soccer
Basketball	Partner Training	Swimming
Boxing	Pilates	Tennis
Cross Country Skiing	Private Personal Training	Triathlon
Football	Racquetball	Volleyball
Golf	Rockclimbing	Walking
Group Personal Training	Running	Wallyball
Hiking	Skiing	White Water Rafting
Ice Skating	Snowboarding	Yoga

Developing your Fitness Program:

1. Please circle how you prefer to exercise:

a) INSIDE OUTSIDE COMBINATION

b) LARGE GROUPS SMALL GROUPS ALONE COMBINATION

c) MORNING AFTERNOON EVENING

2. Realistically, how often a week would you like to exercise? _____x/week

3. Realistically, how much time would you like to spend during each exercise session? _____

4. What are the best days during the week for you to commit to your exercise program?

M T W T F S S

5. If you could design your own exercise program, what would an ideal training week look like to you? Please be specific. List your favorite activities, rest days, time spent etc.

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY

Goal Setting:

How can we help you? Please check that which applies.

❍ Lose Body Fat ❍ Develop Muscle Tone ❍ Rehabilitate an Injury ❍ Nutrition Education
❍ Start an Exercise Program ❍ Design a more advanced program ❍ Safety
❍ Sports Specific Training ❍ Increase Muscle Size ❍ Fun ❍ Motivation
Other_____

In order to increase your chances of being successful at achieving your goals, a certain protocol should be followed. Please ensure all your goals are 'SMART'.

S= Specific (Provide details, how long, how much etc.)
M= Measurable (How will you measure whether you've reached your goals)
A= Attainable (Be realistic, set smaller goals)
R = Rewards-Based (Attach a reward to each goal)
T = Time Frame (Set specific dates for goals)

1. Please list in order of priority, the fitness goals you would like to achieve in the next 3-12 months?

a)_____

b)_____

c)_____

2. Where do you rate health in your life? ❍ Low priority ❍ Medium Priority ❍ High priority

3. How committed are you to achieving your fitness goals? ❍ Very ❍ Semi ❍ Not very

4. What do you think the most important thing we can do to help you achieve your fitness goals?
_____
_____
_____
_____
_____
_____

5. Outline what you feel are the obstacles or your potential actions, behaviors or activities that could impede your progress towards accomplishing your goals (i.e. not training consistently, upcoming vacation, busy season at work, not following the program, allowing other responsibilities to become a priority over exercise etc.).
_____
_____
_____
___

6. Outline 3 methods that you plan to use to overcome these obstacles:

a. _____b. _____c._____

Miscellaneous Questions:

1. How did you hear about us? Please check that which applies.

❍ Brochure ❍ Word of Mouth ❍ Flyer ❍ Newsletter ❍ Website
❍ Health Professional (Doctor, Dietitian, Physical Therapist, etc) ❍ Meal Delivery Program ❍ WRS
❍ Other_____

2. If you were referred to us, who told you about our services?
_____

3. Why did you choose to work with Healthy Balance Fitness instead of another organization? Please check that which applies.

❍ Location ❍ Personal Trainers ❍ Cost ❍ Customer Service ❍ Word of Mouth ❍ Programs
❍ Other_____

4. How far do you live from our facility? _____miles

5. Which newspaper(s) do you read? _____

6. Which magazine(s) do you read? _____