Uplifted UF Fitness

QUESTIONNAIRE

Name:_____ Date_____

Email:_____ Phone:_____

Age:_____ Height:_____ Weight:_____ Sex:_____

OCCUPATION AND LIFESTYLE:

Occupation:

Please circle one for the following questions…

Do you sit for long periods of time? - Y or N

Are there any repetitive movements that you perform while at work? - Y or N

If Yes, please explain…

Does your occupation cause you anxiety or mental stress? - Y or N

If Yes, please explain…

Activity Level at Work - Please circle one

1 (Seated most of day) 2 3 4 5 (On feet most of day)

Sleep Average:_____ hours/day

How would you rate your sleep? (Do you find it hard to fall asleep? Do you find it hard to wake up? Do you sleep through the night or toss and turn?) - [1 = Terrible / 10 = Great]

1 2 3 4 5 6 7 8 9 10

How would you rate your overall energy levels throughout the course of the day? (Please describe when you have highest energy and when you have lowest) [1 = Terrible / 10 = Great]

1 2 3 4 5 6 7 8 9 10

Highest Energy -

Lowest Energy -

NUTRITION:

Top 10 Foods Eaten:

1. 6.
2. 7.
3. 8.
4. 9.
5. 10.

Avg. Meals/day:_____ Avg. Meals Eaten Out/day:_____

Please circle one based off your general knowledge of nutrition (how much you know about what to eat for overall health, specific dieting and/or specific eating?)

1 (Basic - Understand basic nutrition and know good vs bad foods)
2
3 (Decent - Can manage reasonably well with what to eat)
4
5 (Full - Understand and are consciously active about nutrition)

Are you currently involved in a specific diet? (keto, vegan, paleo, etc.) If so, which one, how long have you been doing it and how do you feel on it?

Are you aware of any food allergies, restrictions or sensitivities that you may have? (Gluten, Wheat, Nuts, Lactose etc.)

HEALTH HISTORY / INJURIES:

Please list any current or prior conditions/injuries that effect your health or hinder you from doing certain activities (surgeries/injuries/illnesses/health concerns/family history of disease)

Do you currently take any supplements/medications? If so what type, why are you taking it, what dosages and how long have you taken it for? (This includes any training supplements)

Supplement/Medication	Reason for taking	Dosage	Duration

PERSONAL:

How do you feel about your…

General Health? -

Physical Appearance/Confidence? -

Overall Fitness Level? -

Reasons you work out (to eat what you want, physical altercations, make life easier..)

What motivates you to come to the gym?

What makes you not want to go to the gym?

How do you see progress? (Physical Changes? Breathing differently? Generally happier?)

FITNESS LEVEL AND EXPERIENCE:

Rate your knowledge of fitness as a whole (equipment use, programming, terminology, movements, etc.)

1 (New to working out)

2 (Understand the basics and may need a refreshment)

3 (Decent knowledge, get the gist of most things)

4 (Good understanding and experienced with working out)

5 (You know it all you just need extra guidance)

What is your experience working out? (highschool sports, group fitness classes etc.)

Is there specific equipment you enjoy using? If so, what?

What is your current training program and how long have you been following it?

What does a typical workout look like?

PROGRAMMING:

How many days a week do you/are you planning on working out?

How many days a week do you plan to have a training session?

How long can you/do you stay in the gym to workout?