## **Lifestyle and Health History Questionnaire**



## **CLIENT PERSONAL INFORMATION**

Name:			Date:
Age:	Gender:	Height:	Weight:
Physician Nan	ne and Phone #:		
Emergency Co	ontact Name and Phone	#:	
		EXERCISE	
What exercise	activities do you currently tak	e part in (e.g., running, weigh	tlifting, group exercise, etc.)?
How many day	s per week do you get at leas	t 60 minutes of moderate-inte	ensity 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:
		DIET	
On a scale of 0	to 10, do you consider your c	verall diet to be healthy?	
Are you curren	tly following any kind of diet?	If so, what diet and for what	reason(s)?
How would you	u rank your daily salt intake: lo	ow, medium, or high?	
How would you	u rank your daily sugar intake	low, medium, or high?	
How would you	u rank your daily fat intake: lo	w, medium, or high?	
On a scale of 0	to 10, how effectively are you	u able to control your tempta	tions for junk food?
How many alco	pholic drinks do you consume	per week?	

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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 smoke tobacco or use a vaporizer alternative?			
OCCUPATION			
What is your occupation?			
Does your occupation require extended periods of sitting? (If YES, please explain.)			
Does your occupation require repetitive movements? (If YES, please explain.)			
Does your occupation require you to wear shoes with a heel (e.g., dress shoes, work boots)?			
RECREATION			
Do you partake in any recreational physical activities (golf, skiing, etc.)? (If YES, please explain.)			
Do you have any additional hobbies (gardening, fishing, music, etc.)? (If YES, please explain.)			
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?			

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Do you have any chronic health conditions (such as, but not limited to, cardiovascular disease, pulmonary disorders, hypertension, diabetes, or cancer)? (If YES, please explain.)				
Are you on any medications, and if so, have you received clearance from your doctor to take part in physical activity?				
Additional Notes:				