



## Physical Health & Lifestyle Questionnaire

Name: \_\_\_\_\_ Phone number: \_\_\_\_\_

Gender: male/female Birth date: \_\_\_\_\_

Physician: \_\_\_\_\_ Emergency Contact \_\_\_\_\_

Email address: \_\_\_\_\_

Are you taking any medications (prescriptions or non-prescriptions)?

Is your Doctor aware of your intentions to participate in an exercise program?

Has your Doctor ever told you not to exercise?

How many hours of sleep do you get each night?

In general how would you describe your current state of health?  
Very Good Good Average Poor Very Poor

### Do you have any history of the following?

Heart problem, chest pain or stroke?

Chronic illness or condition?

Recent surgery (last 3 months)?

Pregnancy (now or in the last 3 months)?

Breathing or lung problems? Asthma?

Diabetes or thyroid condition?

Muscle pain or back disorder?

Any previous injury affecting you?

Do you have a seizure disorder? (E.g. epilepsy)

Do you have high blood pressure (hypertension)?

Is your level of cholesterol known to be high?

Do you smoke regularly? If so, how many per day?

Any other health conditions that may affect your physical fitness?

## **Lifestyle Information Form**

### **Physical Activity**

Do you currently participate in any fitness activities? If so how often?

What types of physical activity do you consider “fun”?

What are your personal barriers to exercise (i.e. your reasons for not exercising)?

What physical activity have you been successful with in the past (liked and participated in regularly)?

Do you want to lose weight? If so how much?

What is your current weight and height?

What is your past experience with fitness and /or weight training?

What are your health and fitness goals and expectations?

What is your time commitment per week? Do you prefer free weights or machines?

### Support

Is your significant other or close friend involved in any regular physical activity?

Do you feel any family, friends, or co-workers have negative feelings (i.e. disapproval, resentment) toward your efforts at physical activity?

### Occupation/Leisure

What is your present occupation?

Does your occupation require much activity (i.e., walking, getting up and down, carrying things)?

What are your current leisure activities?

### Stressors

What types of things make you feel stressed?

How do you deal with stress normally?

### Dietary Patterns

How many meals and/or snacks do you have per day?

What would you estimate your daily caloric intake to be per day?

Do you feel "healthy" most of the time?

### Expectations

Specifically describe what you would like to accomplish through your fitness program during the next:

1 month

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2 months

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# Waiver

**This Document is a release of claims and by signing below, you:**

- Represent to Pursuit Fitness and Bobbi Moger that you are in good health and physical condition.

**Name:** \_\_\_\_\_

**Signature:** \_\_\_\_\_

**Witness:** \_\_\_\_\_

**Date:** \_\_\_\_\_