BE YOUR GREATEST OF ALL TIME

HEALTH COACHING & PERSONAL TRAINING

Client intake form

Name:
Date:
Date of birth:

Medical Information

1. How would you describe your present state of health?

2. List current medications, how often you take them, and dosages (include prescriptions and over-the-counter medications).

3. Do you take all of your medications as they have been prescribed by your healthcare provider? Yes No If not, please share why (e.g., cost, side effects, or feeling as though they are unnecessary).

4. Do you take any vitamin, mineral, or herbal supplements? Yes No If yes, list type and amount per day:

5. When was the last time you visited your physician?

6. Have you ever had your cholesterol checked?
Date of test
What were the results?
Total cholesterol:
High-density lipoprotein (HDL):

Low-density lipoprotein (LDL):
Triglycerides:

7. Have you ever had your blood sugar checked?
What were the results?

8. Do you have any current health conditions, diagnoses or concerns?

9. Past injuries?

Family History

1. Has anyone in your immediate family been diagnosed with the following?
Heart disease If yes, what is the relation?
Age of diagnosis:
High cholesterol If yes, what is the relation?
Age of diagnosis:
High blood pressure If yes, what is the relation?
Age of diagnosis:
Cancer If yes, what is the relation?
Age of diagnosis:
Diabetes If yes, what is the relation?
Age of diagnosis:
Osteoporosis If yes, what is the relation?
Age of diagnosis:

Nutrition

1. What are your dietary goals?

2. Have you ever followed a modified diet?
If yes, describe:

3. Are you currently following a specialized eating plan (e.g., low-sodium or low-fat)?
If yes, what type of eating plan?
Why did you choose this eating plan?
Was the eating plan prescribed by a physician?

How long have you been on the eating plan?

4. Have you ever met with a registered dietitian or attended diabetes education classes?
If no, are you interested in doing so?

5. What do you consider to be the major issues with your nutritional choices or eating plan (e.g., eating late at night, snacking on high-fat foods, skipping meals, or lack of variety)?

6. How many glasses of water do you drink per day?

7. What do you drink other than water? List what and how much per day.

8. Do you have any food allergies or intolerance?
If yes, what?

9. How often do you eat out?

10. Do you crave any foods?
If yes, please specify:

Habits

1. Do you drink alcohol?
If yes, how often?
Average amount?

2. Do you drink caffeinated beverages?
If yes, average number per day?
Type?

3. Do you use tobacco?
If yes, how much (cigarettes, cigars, or chewing tobacco per day)?

Physical Activity

1. Do you currently participate in any structured physical activity?
If yes, please describe.
minutes of cardiorespiratory activity per day/times per week.
muscular-training sessions per week
flexibility-training sessions per week
minutes of sports or recreational activities per week
List sports or activities you participate in

2. Do you engage in any other forms of regular physical activity?
If yes, describe

3. Have you ever experienced any injuries that may limit your physical activity?
If yes, describe

4. Do you have any physical-activity restrictions?
If yes, please list

5. What are your honest feelings about exercise/physical activity?

6. What are some of your favorite physical activities?

Occupational

1. What is your occupation?

2. What is your work schedule?

3. Describe your activity level during the work day?

Sleep and Stress

1. How many hours of sleep do you get at night?

2. Rate your average stress level from 1 (no stress) to 10 (constant stress).

3. What is most stressful to you?

4. How is your appetite affected by stress? Increased Not affected Decreased

Weight History

1. What is your present weight?

2. What would you like to do with your weight? Lose weight Gain weight Maintain weight

3. What was your lowest weight within the past 5 years?

4. What was your highest weight within the past 5 years

5. What do you consider to be your ideal weight (the sustainable weight at which you feel best)?

6. What are your current waist and hip circumferences? _____ Waist _____ Hip

7. What is your current body composition? _____% body fat

Goals

1. On a scale of 1 to 10, how likely are you to adopt a healthier lifestyle (1 = very unlikely; 10 = very likely)?

2. Do you have any specific goals for improving your health?
If yes, please list them in order of importance

3. Do you have a weight-loss goal?
If yes, what isIt?
Why do you want to lose weight?