

LIFESTYLE / MEDICAL QUESTIONNAIRE



(Please Print/Type)

Today's Date _ / _ / _

Your Date of Birth / /

CLIENT INFORMATION				
Last Name	First	Middle	<input type="checkbox"/> Mr. <input type="checkbox"/> Miss <input type="checkbox"/> Dr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms	Marital Status (Check one) <input type="checkbox"/> Single / <input type="checkbox"/> Mar / <input type="checkbox"/> Div / <input type="checkbox"/> Sep / <input type="checkbox"/> Wid
Address		City	State	ZIP Code
Home Phone		Cell Phone		Your e-mail
Your IM Name		Occupation		Employer

BODY WEIGHT (in lbs.) INFORMATION / HISTORY				
Your Height	Your Current Weight	Your Weight 2 mths. ago	Your Weight 6 mths. ago	Your Weight 1 yr. ago
Your weight 2 yrs. ago	Your Weight 5 yrs. ago	Your Weight 10 yrs. ago	What you consider to be your ideal weight	What you consider to be a realistic adult weight
Check the people in your family who are overweight: <input type="checkbox"/> Mother / <input type="checkbox"/> father / <input type="checkbox"/> any of your brothers or sisters / <input type="checkbox"/> any of your children / <input type="checkbox"/> father of your children / <input type="checkbox"/> your mother's mother / <input type="checkbox"/> your mother's father / <input type="checkbox"/> your father's mother / <input type="checkbox"/> your father's father / <input type="checkbox"/> no-one				

WAIST MEASUREMENT		HIP MEASUREMENT	
Measure your waist at the level of your belly button. Measuring without clothing is ideal. Stand naturally, and do not suck your stomach in. Measure, keeping the measuring tape level around your body. Do not pull tight. Read the number when the tape measure naturally meets.		Measure your hips around the fullest portion. Do not wear bulky clothes (measuring without clothes is ideal). Keep measuring tape on a level plane around your hips. Do not pull tight and read the number when the tape naturally meets.	
Were you wearing clothing? <input type="checkbox"/> Yes <input type="checkbox"/> No	Measurement <input type="checkbox"/> Inches / <input type="checkbox"/> cm	Were you wearing clothing? <input type="checkbox"/> Yes <input type="checkbox"/> No	Measurement <input type="checkbox"/> Inches / <input type="checkbox"/> cm

HEALTH / MEDICAL INFORMATION				
WOMEN ONLY				
Do you currently menstruate? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of your last menstrual period	Interval between last and previous period	How often you menstruate	Are you currently pregnant <input type="checkbox"/> Yes <input type="checkbox"/> No
ALL				
Do you smoke cigarettes <input type="checkbox"/> Yes <input type="checkbox"/> No	No. of cigarettes you smoke/day	Maximum number of cigarettes you ever smoked regularly	No. of times you have tried to give up smoking	If you no longer smoke, date you quit
Date of your last physical/medical examination		Conditions/illnesses since this last physical/medical exam		Are you willing, if necessary, to have your physician sign off on a medical release for you to begin an exercise/dietary program <input type="checkbox"/> Yes <input type="checkbox"/> No

PLEASE mail, or fax copies of your latest blood work results with this form.

For each of the following, please check YES, NO, and/or FAMILY HISTORY, to indicate whether or not you have the specified condition, or a close family member has the condition (mother, father, grandmother, grandfather, siblings or children).

If you check YES, please list the dates during which you had/have the condition. If you check family history, please indicate the family member.

	YES	Dates	NO	Family History
Diabetes Mellitus	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain, any Heart Problems or Angioplasty	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Respiratory Disease	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Cerebrovascular Disease	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Kidney Problems	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Gynecological Disorders	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Problems	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Psychiatric Disorder	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
History of Cancer	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Anorexia Nervosa	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Bulimia Nervosa	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Binge Eating Disorder	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Drug Dependence	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Alcoholism	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Other (explain)			<input type="checkbox"/>	<input type="checkbox"/>

List all illnesses / conditions / surgeries you currently have, or have had in the past, and whether you are taking medication for them or not.

Conditions / illnesses / surgery	Date of Onset	Medication

List all other medications, vitamins or supplements you are currently taking, and your reason for taking them.

Medication / Supplement	Dosage / Amount	Reason

DIET INFORMATION / HISTORY

Are you currently dieting <input type="checkbox"/> Yes <input type="checkbox"/> No	How many times have you dieted in the past 3 years	List any meal supplements (e.g. Slimfast), or prepared foods (e.g. Jenny Craig) that you take.
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Do you drink alcoholic beverages such as wine, beer or liquor <input type="checkbox"/> Yes <input type="checkbox"/> No	If YES, indicate the number of servings on a weekly basis:	Weekly servings of beer (1 can/12oz = 1 serving)	Weekly servings of wine (1 glass/4 oz = 1 serving)	Weekly servings of liquor (1 shot = 1 serving)
Do you drink caffeinated beverages such as coffee, tea, or soda <input type="checkbox"/> Yes <input type="checkbox"/> No		Weekly servings of coffee (1 cup/8oz = 1 serving)	Weekly servings of tea (1 cup/8 oz = 1 serving)	Weekly servings of soda (1 can/12oz = 1 serving)
Do you drink sugared (non-diet) beverages such iced tea, or soda <input type="checkbox"/> Yes <input type="checkbox"/> No		Weekly servings of iced tea (1 cup/8 oz = 1 serving)	Weekly servings of soda (1 can/12oz = 1 serving)	

If you often choose “**fat free**” products over regular (e.g. cookies, chips, etc) list the products you use:

If you often choose “**sugar free**” products over regular (e.g. cookies, jellies, etc) list the products you use:

List foods/drinks that are special favorites, and which you do not wish to eliminate from your diet:

Indicate which meals during the typical day for which you are personally responsible for preparing/purchasing/choosing, and for which others are responsible (e.g. wife, mother, secretary, etc.)

MEAL	WHOSE RESPONSIBILITY ?
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PHYSICAL ACTIVITY INFORMATION / HISTORY

Do you currently exercise regularly <input type="checkbox"/> Yes <input type="checkbox"/> No	If YES, date you began your current exercise program:	Explain the type of exercise you do, and how much		
		Exercise /Activity	# Minutes/session	# Times/ Week
Number of hours of television/computer games/internet each week	Do you snack / smoke / drink while watching the TV, or on the computer <input type="checkbox"/> Yes <input type="checkbox"/> No	Physical Activity (s) you like		Physical Activity (s) you dislike

LIFESTYLE INFORMATION

Time of day you have most energy	Time of day you have least energy	On a low-high scale, rate your general level of stress	Number of hours of sleep each night	How rested you feel on waking each morning
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List, in order from highest to lowest, the things that cause you most stress: (hit enter bar to make list)	List of activities you use /have used to reduce your stress, and how often you practice them		
	Activity	Currently Practice?	Frequency
		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	

List the behaviors you wish to change to move towards a more healthy and well lifestyle:	For each of these activities, assign a priority (1=high priority; 5=lower priority)	Check the column which best represents the amount of commitment you have in trying to address this behavior:				
		I am thinking about it, but am not ready to do anything in the next 6 months	I may do something in the next 6 months	I am ready to address this within the next month	I am already working on this	I have been working on this for at least 6 months now
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

List characteristics you are looking for in a coach:	The amount of time you are willing to put into working with your coach, and alone to change your targeted behaviors	
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The above information is true, and accurate to the best of my knowledge.

X _____
 PARTICIPANT / GUARDIAN SIGNATURE DATE