



LifeStyle Fitness
WELLNESS | LIFESTYLE | FITNESS

New Client Questionnaire

NAME: _____
HOME ADDRESS _____
CITY _____ STATE _____ ZIP _____
PHONE: (home) _____ (work) _____ EMAIL: _____
AGE: ____ DATE OF BIRTH _____ SEX: ____ (M or F) HEIGHT _____
CURRENT WEIGHT: _____ DESIRED WEIGHT: _____

PRIMARY TRAINING & NUTRITION OBJECTIVE: (select one or more)

Lose Weight Maintain Weight General Fitness Strength Gain Rehab/ Core Stability

Specify Sport(s) or other objectives (e.g., body parts, cross-training) not listed above

HOW MANY MONTHS DO YOU THINK IT WILL TAKE YOU TO ACHIEVE YOUR GOAL(S)?

2 3 4 5 6 7 8 9 10 11 12+

Please Estimate your DAILY ACTIVITY LEVEL

Not Active – You work more than 8 hours per day, have little or no free time, frequently watch TV in the evening and do not participate in a fitness activity on a regular basis.

Light – You enjoy reading, studying and computer work or watch more than 3 hours per day of TV and do not participate in a fitness related activity on a regular basis.

Moderate – You enjoy a variety of interests and watch some TV on a regular basis. You usually participate in a fitness related activity 3 times per week. You watch less than 3 hours of TV daily and 1½ hours of computer time.

Active – You are involved with a fitness activity at least 5 days per week and prefer to be outdoors most of the time. You view no more than 2 hours per day of TV and 1 hour of computer time.

Very Active – You do not enjoy sitting and relaxing, you prefer doing sport activity rather than watching TV. You are actively participating in a fitness relative activity on a daily basis. You see fitness as a large part of each day.

How many hours of sleep are you getting each night? _____ (estimate)

Are you taking any supplements, multi vitamins or weight loss supplements? ____ (Yes or No)

If YES, which are you taking?

If NO, are you interested in learning about which supplements, multi vitamins or weight loss supplements could be right for you? _____ (Yes or No)

Training History

Over the past year or two, what has your TRAINING EXPERIENCE been?

- Sedentary = Those who have little or no recent history of training or dieting.
- Beginners = Those just getting into training and dieting within the past year or two, who workout 1-3 times weekly.
- Intermediates = Those who have worked out at least a year or two, are familiar with weight training exercises, are serious about making changes with their training and nutrition and exercise 3-5 times weekly.
- Upper-Intermediates = Athletes and fitness-oriented people who are already in pretty good shape and who are ready to “make the commitment” to amplify their training efforts to the maximum.

How would you assess your present PHYSICAL CONDITION?

- Never Exercised = Those who have little or no history of training or dieting since their school days.
- Fair = Individuals who have been working out off and on, but not seriously.
- Good = Those who are thoroughly familiar with weight training exercises, and have exercised very regularly.
- Excellent = Athletes and fitness-oriented people who are in shape and who have been highly committed to their training and nutrition.

CLIENT’S MEDICAL HISTORY:

Have you experienced the following?

Y N Do you have any joint or spinal injuries/aches or pains?

If so, where? _____

Y N Are you seeking treatment?

If so, by whom? _____

Y N Heart Attack, coronary bypass, or other coronary surgery?

Y N Chest discomfort (especially with exertion)?

Y N High blood pressure?

Y N Extra, skipped or rapid heart beats/palpitations?

Y N Heart murmurs, clicks, or unusual cardiac findings?

Y N Unusual shortness of breath?

Y N Ankle swelling?

Y N Light headedness or fainting?

Y N Pulmonary disease?

Y N Abnormal blood lipids (cholesterol, triglycerides)?

Y N Stroke?

- Y N Recent illness, hospitalization or surgical procedure within the past 4 months?
Y N Medications of any kind? (list on back)
Y N Diabetes or other metabolic disorders?
Y N Are you pregnant now?
Y N Is there any reason your physician would object to your dieting?
Y N Is there any reason your physician would object to your exercising?
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Physician Contact Information

NAME: _____
OFFICE ADDRESS _____
CITY _____ STATE _____ ZIP _____
PHONE: (office) _____ (emergency) _____

EMERGENCY CONTACT

NAME: _____ RELATIONSHIP: _____
BEST NUMBER(S) TO CONTACT: _____

WAIVER

I, the undersigned, have read, understand, and have answered the above health/medical survey questions fully and truthfully. I have consulted with my personal physician regarding my medical fitness to engage in strenuous exercise and a nutritional support program. I do hereby intend to be legally bound for myself and waive release of any and all rights and claims for damages as a client/patient, that I may have against Haque Chiropractic Inc. & Lifestyle Fitness and the Fitness Trainer/ Physician administering the instrument for any and all injuries suffered while following the training and/or nutrition program provided to me.

DATE: _____

CLIENT