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Exercise and Health Status Questionnaire

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Please complete this questionnaire and bring it with you to your consultation.

Section 1 – Your Personal Details

Name	_____		
Address	_____		

		Post Code	_____
Telephone	Home	_____	Work _____
	Mobile	_____	
E-mail	_____		
Occupation	_____		
Date of Birth	_____		

Section 2 – Emergency Contact Details

Name	_____		
Address	_____		

		Post Code	_____
Telephone	Home	_____	Work _____
	Mobile	_____	

Section 3 – Your Doctor's Details

Name	_____		
Address	_____		

		Post Code	_____
Telephone	_____		

Section 4 – About Your Health Goals

1 What health goals would you like to achieve in the next 3 months?

2 What long term health goals would you like to achieve over the next 12 months?

3 Name 3 things you will do in order to improve your health.

Section 5 – About Your Exercise Habits

4 What are your main reasons for starting a fitness programme?

- | | |
|---|---|
| <input type="checkbox"/> General conditioning | <input type="checkbox"/> Weight/fat loss |
| <input type="checkbox"/> Stress management | <input type="checkbox"/> Muscular strength |
| <input type="checkbox"/> Aerobic fitness | <input type="checkbox"/> Flexibility |
| <input type="checkbox"/> Enjoyment | <input type="checkbox"/> Social |
| <input type="checkbox"/> Improve self esteem | <input type="checkbox"/> Disease prevention |
| <input type="checkbox"/> Appearance | <input type="checkbox"/> Other _____ |

5 How would you describe your fitness condition in terms of your general health and fitness?

6 Have you ever done any structured exercise? Yes No

If you answered No, please go to question 12.

7 What was it?

8 How many times a week did you exercise? _____ days per week

9 How long did you stick with it?

10 Did you get the results you wanted? Yes No

If you answered No, please go to question 12.

11 If you did, why did you stop?

12 What activity do you enjoy doing the most?

13 What do you like doing the least?

14 What would you identify as the main barriers preventing you from exercising in the future?

- | | |
|--|---|
| <input type="checkbox"/> Procrastination | <input type="checkbox"/> Lack of motivation |
| <input type="checkbox"/> No time | <input type="checkbox"/> Lack of facilities |
| <input type="checkbox"/> Injury | <input type="checkbox"/> Lack of ability/fitness |
| <input type="checkbox"/> Financial cost | <input type="checkbox"/> Lack of relevant knowledge |
| <input type="checkbox"/> Family responsibilities | <input type="checkbox"/> Medical advice |

Section 6 – About Your Nutritional Needs

15 On a scale of 1 – 10 (1 being very low quality, 10 being very high quality), how would you assess the quality of your diet? _____

16 Do you follow any particular diet? *Please tick all boxes that apply.*

- | | |
|--|--|
| <input type="checkbox"/> Vegetarian and fish | <input type="checkbox"/> Vegetarian |
| <input type="checkbox"/> Vegan | <input type="checkbox"/> Allergy elimination |
| <input type="checkbox"/> Other _____ | |

17 Would you like any advice or support to help you make any changes to the quality of your diet? Yes No

18 If you answered Yes, please give details of your 3 key goals.

- i) _____
- ii) _____
- iii) _____

19 Have you had your diet analysed before? Yes No

If Yes, when?

Section 8 – About Your Structural Health

26 Do you have any of the following conditions? Please tick all boxes that apply.

- | | |
|---|--|
| <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Shoulder injury |
| <input type="checkbox"/> Rheumatoid arthritis | <input type="checkbox"/> Head/neck injury |
| <input type="checkbox"/> Knee/thigh injury | <input type="checkbox"/> Arm/elbow injury |
| <input type="checkbox"/> Back pain/injury | <input type="checkbox"/> Hip/pelvis injury |
| <input type="checkbox"/> Wrist/hand injury | <input type="checkbox"/> Nerve damage |
| <input type="checkbox"/> Ankle/foot injury | <input type="checkbox"/> Bone fracture |
| <input type="checkbox"/> Swollen joints | |

27 If you answered Yes, please give details.

28 Are these or any other injuries aggravated by exercise? Yes No

If you answered No, please go to question 27.

29 If you answered Yes, please give details.

30 Are you presently receiving physical therapy? Yes No

Section 9 – About Your Medical History (based on your answers in this section we may ask your permission to seek your GP's advice before commencement of any exercise programme)

31 Is there a family history of any of the following medical conditions?

- | | |
|---|---|
| <input type="checkbox"/> Heart problems | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Early menopause |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Other medical conditions |

If Other, please give details.

For office use only – to be completed by your trainer

GP to be contacted? Yes / No

If yes

Date letter sent _____ Letter ref _____

Date GP response received _____

32 Have you had major surgery in the last 10 years? Yes No

If Yes, please give details.

33 Have you had minor surgery in the last 2 years? Yes No

If Yes, please give details.

34 Please tick any of the following for which you have been diagnosed or treated by a physician or health professional.

- | | |
|--|--|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Heart problem |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Chest pains |
| <input type="checkbox"/> Other | |

If Other, please give details.

35 Tick all medicine taken in the last 6 months.

- | | |
|--|---|
| <input type="checkbox"/> Blood thinner | <input type="checkbox"/> Diabetic medication |
| <input type="checkbox"/> Epilepsy medication | <input type="checkbox"/> Diuretics |
| <input type="checkbox"/> Beta blockers | <input type="checkbox"/> Other medication which might affect exercise |

If Other, please give details.

36 Tick the box if you ever experience any of the following symptoms. Do you

- ever get unusually short of breath with very light exertion?
- ever have pain, pressure heaviness or tightness in the chest area?
- regularly have unexplained pain in the abdomen, shoulder or arm?
- ever have severe dizzy spells or episodes of fainting?
- regularly get lower leg pain during walking that is relieved by rest?
- ever feel "skips", palpitations or runs of fast beats in your chest?

37 Please list any health problems you suffer from, not already mentioned.

38 Are you currently pregnant or have you given birth in the last 12 months?

Yes No

Declaration:-

I confirm that to the best of my knowledge the information given within this document is correct, and understand that it will be treated with strictest confidence by _____ (and by those acting for and on behalf of _____ for services that I may wish to engage in now and in the future.

Signature : _____

Date : _____