

## Exercise/Dietary Habits and Goal Setting

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

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

### Exercise Habits

1. How many times a week are you active enough to break a sweat?
2. When you exercise, how long are generally active?
3. On a scale of 1-10 (10 being the greatest) how intense is your typical activity?
4. How many years have you exercised regularly?
5. Is your occupation inactive (desk job), moderately active (house work), or heavily active (carpentry)?
6. Please check all activity preferences or interests:  
 Kickboxing class       Running       Spinning  
 Team sports       Swimming       Free Weights  
 Outdoor cycling       Walking       Step Aerobics  
 Martial arts       Yoga/Pilates       Dance  
 Other (please list): \_\_\_\_\_

### Dietary Habits

1. Do you consider yourself overweight, underweight, or at the right weight?
2. What is your ideal weight?
3. Have you ever dieted? \_\_\_\_\_ If yes, please explain method used. \_\_\_\_\_
4. Please check all that apply:  
 I pursue a low-fat diet.  
 I eat at least 5 servings of fruits/vegetables every day.  
 I almost always eat a full, healthy breakfast.  
 I rarely eat high-sugar or high-fat desserts.  
 I seldom consume red meats.  
 I almost always drink 8 glasses of water per day.

### Goals

Please check all your personal health and fitness goals:

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> General fitness            | <input type="checkbox"/> Muscular strength | <input type="checkbox"/> Muscular size |
| <input type="checkbox"/> Aerobic endurance          | <input type="checkbox"/> Sport specific    | <input type="checkbox"/> Lose weight   |
| <input type="checkbox"/> Look better                | <input type="checkbox"/> Reduce stress     | <input type="checkbox"/> Feel better   |
| <input type="checkbox"/> Enhanced mood              | <input type="checkbox"/> Flexibility       | <input type="checkbox"/> Injury rehab  |
| <input type="checkbox"/> Lower cholesterol          | <input type="checkbox"/> Improve diet      | <input type="checkbox"/> Stop smoking  |
| <input type="checkbox"/> Other (please list): _____ |  |  |

Please record one *specific* commitment to help you reach your goals. (Ex: Come to the Recreation Center to strength train on my own 1x/wk.) Work with your trainer to develop more, and reward yourself for keeping your commitments!

## Medical History Questionnaire

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

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

1. Please check all that apply:

- Personal history of diabetes
- Personal history of asthma, pulmonary disease, or lung disease
- Personal history of high cholesterol (>200mg/dl)
- Diagnosed with hypertension (high blood pressure) by a physician, past or present
- Difficulty breathing or shortness of breath
- Problems with dizziness or fainting
- Sudden tingling, numbness, or loss of feeling in extremities or face
- Heart murmur
- Arthritis
- Current cigarette smoker
- Currently pregnant
- Current lifestyle you would characterize as "sedentary"
- Family history of cardiac or pulmonary disease prior to age 55

2. When was the last time you had a physical exam? \_\_\_\_\_  
At this time did the doctor impose any activity restrictions? If yes, please describe:

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3. Please check any medications/supplements you are currently using:

- |   |   |
|---|---|
| <input type="checkbox"/> Diuretics                          | <input type="checkbox"/> Beta Blockers              |
| <input type="checkbox"/> Vasodilators                       | <input type="checkbox"/> Alpha Blockers             |
| <input type="checkbox"/> Calcium Channel Blockers           | <input type="checkbox"/> Other Cardiovascular       |
| <input type="checkbox"/> NSAIDS/Anti-inflammatories (Advil) | <input type="checkbox"/> Cholesterol                |
| <input type="checkbox"/> Diabetes/Insulin                   | <input type="checkbox"/> Other (please list below): |

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4. Please list any surgeries/operations or injuries that may affect your ability to exercise.

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