



Health Questionnaire and Release

Please bring this form to your first appointment

First Name: _____ Last Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: ____/____-____ Date of Birth: ____/____/____ Age: _____ Sex: M F

EMAIL: _____@_____

Do you have children? YES NO What are their ages? _____

Work Phone Number: _____ Occupation: _____ Employer: _____

Emergency Contact: _____ **Phone Number** _____

Your Physician: _____ Physician's Phone: ____/____

Modified PAR-Q (Physical Activity Readiness Questionnaire)

___ YES ___ NO Has your doctor ever advised you that you have a heart condition that would affect your level of physical activity?

___ YES ___ NO Do feel pain in your heart or chest when you perform physical activity?

___ YES ___ NO In the past month, have you had any chest pain when you were doing physical activity?

___ YES ___ NO Do you lose your balance because of dizziness or do you ever lose consciousness?

___ YES ___ NO Do you have a bone or joint problem that could be made worse by a change in your physical activity?

___ YES ___ NO Is your doctor currently prescribing drugs for your blood pressure or any heart condition?

___ YES ___ NO Are you currently taking any medications that raise your resting heart rate?

___ YES ___ NO Have you had your cholesterol levels checked with a blood test in the past year?

___ YES ___ NO Have you had your glucose and triglyceride levels checked with a blood test in the past year?

___ YES ___ NO Have you completed a physical exam with your physician in the past year?

___ YES ___ NO Do you know of any reason why you should not participate in any exercise, physical activity or a physical fitness program?

If you have answered "yes" to any of the above questions, we advise you to consult with your physician before beginning an exercise program. All people new to exercise should begin with light intensity exercise.

I have read and accurately answered the PER-Q and understand the recommendations listed above.

Signature (co-signed by adult if under 18)

____/____/____
Date

Past and Present Personal Health Profile (check any and all that apply):

Heart Disease Diabetes High Blood Pressure
 Arterial Disease Cancer Asthma
 Lung Disease Anemia Epilepsy

Family History/Health Profile (check any and all that apply to immediate blood relatives):

Heart Disease Hypertension Heart Failure
 Heart Failure Diabetes Cancer
 Stroke Cancer High Cholesterol

Please provide details regarding any medical condition(s) and recommendations made by your physician regarding exercise.

Tobacco Usage

YES NO Do you currently smoke or use tobacco products? If yes, how much per day?

If you smoked or used tobacco products in the past, how long has it been since you quit?

Medications/Prescriptions

YES NO Are you currently taking any medications or prescriptions? If yes, please provide the name(s) and the reason for taking.

Medication/Prescription Reason For Taking

Please indicate any other information you think is important for us to know prior to your beginning and engaging in fitness testing and/or an exercise program:

Primary Physician and other Health Care Professionals

Primary Physician: _____ Phone: _____

Please provide names and telephone numbers of any other medical professionals who may be presently administering treatment and may need to be contacted in regard to a structured exercise regimen:

Name Phone

History of Physical Activity:

YES ___ NO ___ Are you currently involved in a cardiovascular exercise program such as walking, jogging, cycling, swimming, group exercise, etc?

YES ___ NO ___ Are you currently involved in any form of resistance/weight training?

YES ___ NO ___ Have you ever worked with a personal trainer?

YES ___ NO ___ Have you been physically active (> 3 hours of exercise per week) at some point during the last six months?

YES ___ NO ___ Are you currently involved in any sports either recreationally or competitively? If yes, what sport(s) are you playing?

YES ___ NO ___ Are you currently involved in any other exercise routines? (yoga, pilates, tai chi, martial arts, etc). If yes, what are they and how often do you perform them?

YES ___ NO ___ Do you have any injuries (past or current) that would limit your ability to participate in an exercise program? If yes, please describe.

Lifestyle Profile

On a scale of 1-5 with 1 being the lowest and 5 the highest, how would you rank your typical daily energy levels?

1 2 3 4 5

How much sleep on average do you get each night?

__ 3-5 hrs __ 6-8 hrs __ > 8 hrs

On a scale of 1-5 with 1 being the lowest and 5 the highest, how would you rank your typical daily stress levels?

1 2 3 4 5

How often do you find yourself missing meals because you simply get too busy?

__ Rarely __ Occasionally __ Frequently

How often do you find yourself using food or alcohol to cope with emotional stress?

__ Rarely __ Occasionally __ Frequently

Nutrition Profile

YES ___ NO ___ Do you eat breakfast on a daily basis?
If yes, what does it typically consist of?

How many meals on average do you eat each day?

__ 1-2 __ 3-4 __ 5-6

How many times per week on average do you eat at fast food restaurants?

0 1-2 3-4 5 or more

How many times per week on average do you eat out for dinner?

0 1-2 3-4 5 or more

How many servings of vegetables do you typically eat each day?

(1 serving = ½ cup of non-leafy vegetables or 1 cup leafy vegetables such as romaine lettuce)

0 1-3 4-6 7 or more

How many servings of fruits do you typically eat each day?

(1 serving = 1 medium fruit or ½ cup of cut up fruit)

0 1-3 4-6 7 or more

How many servings of soda do you drink on average each day? (1 serving size = 12 ounces)

0 1-2 3-5 6 or more

How many servings of coffee do you drink on average each day (1 serving = 6-8 ounces)

0 1-2 3-5 6 or more

YES NO Do you drink alcohol?

If yes, please describe how frequently and in what amount.

(1 serving = 12 ounces of beer, 5 ounces of wine, 1 ½ ounces of liquor)

How many ounces of water do you drink on average each day?

(Note: a typical water bottle is 12-16 ounces)

less than 16 ounces 16-32 ounces 33-64 ounces 65-128 ounces

Do you take any vitamins, minerals, herbs or supplements on a daily basis? If so what do you take?

YES NO Are you completing any diet, doctor prescribed or other at this time than contains specific foods and quantities.

If yes, please describe the diet.

Client Compatibility & Expectations

Please write down what you would specifically like to achieve with your program?

Do you have any specific goals that you'd like to achieve?

Example: dress size, body fat %, body weight, inches, etc)

What are your expectations in terms of the time it will take you to reach these specific goals?

Are there any specific activities you would like to be able to do as a result of your exercise program?

Describe what behaviors or actions if any you feel you must commence, change, or stop in order to reach these goals?

What do you feel will be your biggest obstacle(s)?

Are there any preferences you have that could help us match you with the appropriate trainer?
Example: equipment likes/dislikes, exercise likes/dislikes, motivational preferences, accountability needs, general likes/dislikes, any fear or apprehensions, etc.

What do you consider to be the top priorities in your program?

- | | |
|--|--|
| <input type="checkbox"/> Weight Loss | <input type="checkbox"/> Increasing Energy |
| <input type="checkbox"/> Increasing Muscle Mass | <input type="checkbox"/> Decreasing Pain & Stiffness |
| <input type="checkbox"/> Improving Function and Movement | <input type="checkbox"/> Toning and Firming |
| <input type="checkbox"/> Improving Athletic Performance | <input type="checkbox"/> Weight Gain |

Personal Goals

1. List your personal reasons for starting this program:

2. List your personal reasons for starting this program:

Signature (co-signed by adult if under age 18)

___/___/___

Date



How Ready are You to CHANGE?

Which one of these most relates to your goals (Exercise or Nutrition)

Do you currently do some type of **Aerobic Exercise** (ie, very fast walking, jogging, using cardio equipment such as a treadmill or elliptical, or any activity which elevates the heart rate significantly for thirty minutes) on **five or more days of the week**? **YES**

or

Do you currently follow a researched-based Nutrition Plan designed to help you lose/maintain your weight and reduce risk factors for disease? **YES**

Are you accumulating at least 30 minutes of exercise, or eating better at least one day per week? **YES NO**

Do you intend to increase your exercise? **YES NO**

On a scale from **1-10** (10 being the most), how much do you want to reach your goals? _____

On a scale from **1-10** (10 being the most), how much are you willing to put towards you meeting your goals? _____

Food Safety Agreement

Your Initials 

I will drink at least 16 ounces of water at each meal AND in between each meal. _____

I will eat 5 small meals every day, with a maximum of 4 hours between meals. _____

I will use the 24 Day (get my metabolism started) challenge properly - in conjunction with my proper eating habits - to maximize my results and to get more vitamins and minerals that I need to help me reach my goals. _____

I will log my eating for at least two weeks and show my trainer each time I see him/her. _____

I will limit myself from "eating out" and start planning every meal and snack at least a day ahead of time.



Agreement of Release and Waiver of Liability

I, (print your name): _____ hereby agree to the following:

1. That I am participating in the exercise and nutrition programs offered by Shaping Concepts of Hilton Head, LLC during which I will receive information and instruction about health and fitness. I recognize that the activities offered by Shaping Concepts of Hilton Head, LLC require physical exertion that may be strenuous and may cause physical injury, and I am fully aware of the risks and hazards involved.
2. I understand that it is my responsibility to consult with a physician prior to and regarding my participation in the activities listed above in section 1. I represent and warrant that I am physically fit and have no medical condition that would prevent my full participation in the activities listed in section 1.
3. In consideration of being permitted to participate in the activities listed in section 1, I agree to assume full responsibility for any risks, injuries or damages, known or unknown, which might incur as a result of participating in the program.
4. In further consideration of being permitted to participate in the activities listed in section 1, knowingly, voluntarily and expressly waive any claim I may have against Shaping Concepts of Hilton Head, LLC for injury or damages that I may sustain as a result of participating in the activities listed in section 1.

I have read the above release and waiver of liability and fully understand its contents. I voluntarily agree to the terms and conditions above.

Participant Signature ▲

Date ▲

If participant is less than 18 years of age:

As legal guardian of: _____, I consent to the above terms and conditions.

Signature of Parent/Guardian of participant ▲

Date ▲