wendyfitness.com

PROGRAM DESIGN QUESTIONNAIRE

Name:_____

Age:_____ Date of birth:_____

Address:_____

Telephone: _____

Occupation:_____

Place of Employment:_____

Do you share a household with others? _____

With whom (spouse, partner, children, parents, etc.)

_____

Are they supportive of your efforts? _____

Are you a full-time caregiver to a parent or someone with special needs?

_____

Person to contact in case of an emergency:

_____

Phone#_____

Relationship:_____

When was your last doctor's visit, and what was the reason?

_____

Date of last physical? _____

Current weight?_____

Height?_____

(continued on next page)

YOUR Past History	**Your FAMILY'S Past History**	**Your Present Symptoms**
Have you ever had …	Have your parents/ siblings/grandparents ever had …	Do you CURRENTLY or have you RECENTLY had …
High blood pressure YES NO	Heart attacks YES NO	Chest pain/ discomfort YES NO
Any heart trouble YES NO	High blood pressure YES NO	Shortness of breath YES NO
Disease of the arteries YES NO	High cholesterol YES NO	Heart palpitations YES NO
Varicose veins YES NO	Stroke YES NO	Skipped heart beat YES NO
Lung disease YES NO	Diabetes YES NO	Cough on exertion YES NO
Asthma YES NO	Congenital heart defect YES NO	Coughing of blood YES NO
Kidney disease YES NO	Heart operations YES NO	Dizzy spells YES NO
Hepatitis YES NO	Early death YES NO	Frequent headaches YES NO
Diabetes YES NO	Any other family illnesses? Please list:	Frequent colds YES NO
Heart murmur YES NO		Back pain YES NO
Arthritis YES NO		Orthopedic problems YES NO

Hospitalizations: Please list recent hospitalizations

year reason

_____

_____

_____

_____

(continued on next page)

Have you ever had an eating, exercise- or other food-related disorder (including but not limited to anorexia or bulimia)? Please explain:

_____

_____

_____

_____

Have you ever been treated for anxiety and/or depression? When?

_____

_____

_____

_____

Any other medical problems/ concerns not already identified?

Yes___No___(Please list below)

_____

_____

Have you ever had your cholesterol measured?

Yes___ No___

If yes, (value)_____(date)_____

Are you taking any Prescription or Non-Prescription medications?

Yes___ No___ (include birth control pills)

Medication	Reason for Taking	For How Long?

_____

_____

_____

_____

(continued on next page)

Do you currently smoke?

Yes___ No___

If so, what? Cigarettes_____ Cigars_____ Pipe_____ Other_____

How much per day: <.5 pack_____ 0.5 to 1 pack_____ >2 packs_____

Have you ever quit smoking?

Yes_____ No_____ When?_____

For how many years and how much did you smoke?

_____

Do you drink any alcoholic beverages?

Yes_____ No_____

If yes, how much in 1 week?

Beer_____(cans) Wine_____ (glasses) Hard liquor_____ (drinks)

Do you drink any caffeinated beverages?

Yes_____ No_____

If yes, how much in 1 day?

Coffee_____ (cups)

Tea_____(glasses)

Soft drinks_____ (cans)

(continued on next page)

Activity Level Evaluation

What is your occupational activity level?

Sedentary___ Light___ Moderate___ Heavy___

Do you currently engage in vigorous physical activity on a regular basis?

Yes_____ No_____

If so, please describe:

_____

_____

_____

How many days per week?_____

How much time per day? (check one)

less than 15min_____ 15-30min_____ 30-45min_____ more than 60min_____

Do you ever have uncomfortable shortness of breath during exercise?

Yes_____ No_____

Do you ever have chest discomfort during exercise? Yes_____ No_____

If so, does it go away with rest?

_____

Do you engage in any recreational or leisure-time physical activities on a regular basis?

Yes_____ No_____

If so, what activities?

_____

On average:

How often?_____ times/week

For how long?_____ time/session

(continued on next page)

Are you currently following a structured nutrition or diet program?

Yes_____ No_____

If so, what is the purpose of this program? (i.e., weight loss, body

composition change, muscle growth, medical, etc.)

_____

How long have you been following the program? _____ months

Is the plan prescribed by your doctor?

Yes_____ No_____

Are you working with a dietitian?

Yes_____ No_____

Have you used weigh reduction diets in the past?

Yes_____No_____

If yes, how often and what type?

_____

_____

_____

If possible, please keep a food log for 1 to 3 days of a TYPICAL day of eating. You can do this online via an app such as myfitnesspal, Lose It!, Fitbit, SparkPeople, or any one of the dozens of other free offerings online.

If possible, please print/screenshot/otherwise share the journal with me.

If this isn't possible, please write down the info and send it to me.

Make a list of your favorite healthy foods:

1.

2.

3.

4.

5.

(Continued on next page)

Make a list of your least favorite healthy foods:

1.

2.

3.

4.

5.

Have you ever been placed on a specific nutritional program before?

Yes_____ No_____

If so, who created it for you and what did it consist of?

_____

_____

_____

_____

What were your results?

_____

_____

_____

_____

Is there any other important information you think I should be aware of in the design of your program?

_____

_____

_____

_____

(Continued on next page)

Waiver of Liability

I, _____, agree to allow Wendy Watkins and other instructors Wendy Watkins Fitness Coaching to design a fitness program for me to enhance my health and fitness goals.

I will follow that program to the best of my ability and I will not hold Wendy Watkins, Thrive Fitness Studio or any of instructors, trainers or other personal affiliated with Thrive Fitness Studio liable for any problems, injuries or illnesses that might occur due to a sudden change in my current behavior.

I understand that physical activity carries with it some risk of injury.

I also understand this program does not replace the expert advice or medical treatment of my own private doctor.

I have given Wendy Watkins Fitness Coaching all necessary information about myself to prevent any possible complications.

Signature:_____

Date:_____