*Lifestyle Assessment Questionnaire*

# Infinite Strategies Coaching

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| --- | --- | --- | --- |
| Client Name:  |  | Date: |  |

Complete sections **B-C-D-E-F**

**A. Vital Statistics:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Age: |  | Fitness age: |  | Height: |  |
| Weight: |  | Ideal weight: |  | Lean weight: |  |
| Fat Weight: |  | Body fat%: |  | BMI%: |  |

**PLEASE ANSWER EACH OF THE FOLLOWING QUESTIONS AS ACCURATELY AS POSSIBLE**

**B. Medical/Injury History**

|  |  |
| --- | --- |
| 1. List any major or minor surgeries in the last five years:
 |  |
| 1. List any prescribed medications and length of period:
 |  |
| 1. Have you been under doctor supervision in the last 5 years:
 | Yes \_\_\_ No\_\_\_ |
| 1. Any major hospitalizations in the last 5 years?
 | Yes \_\_\_ No\_\_\_ |
| 1. Have you ever had major bowel issues?
 | Yes \_\_\_ No\_\_\_ |
| 1. Are you diabetic?
 | Yes \_\_\_ No\_\_\_ |
| 1. When was your last well woman exam?
 |  |
| 1. Do you have a family history of high blood pressure, heart disease, high cholesterol, cancer or diabetes?
 | Yes \_\_\_ No\_\_\_ |
| 1. Have you ever been diagnosed with an irregular heartbeat?
 | Yes \_\_\_ No\_\_\_ |
| 1. Any broken bones in the last 5 years?
 | Yes \_\_\_ No\_\_\_ |

**C. Psychosocial Data/Activity Level**

|  |  |
| --- | --- |
| 1. Describe your job (are you seated all day, types of interaction, hours etc.)
 |  |
| 1. What is your highest education level?
 | High school\_\_\_ College\_\_\_Graduate degree\_\_\_ |
| 1. What is your marital status?
 | Married\_\_\_ Single\_\_\_Divorced\_\_\_ Separated\_\_\_ |
| 1. How often do you go out per month?
 | 1-2 times\_\_\_ 3-4 times\_\_\_ |
| 1. What are you favorite types of socialization (club, bar, theater etc.)?
 | Dinner/Movie\_\_\_ Club\_\_\_ Dinner Party\_\_\_ Theater\_\_\_ Spend time at home\_\_\_ |
| 1. How often do you cook?
 | 1-2 times per week\_\_\_ 3-4 times per week\_\_\_ |
| 1. What type of physical activities do you engage in on a daily basis? (Tennis, bowling, cycling, walking etc.)
 |  |
| 1. How many hours of television do you watch per evening?:
 | 30 minutes -1 hour\_\_\_1-2 hours\_\_\_3 hours or more\_\_\_ |
| 1. What time do you normally go to bed?
 |  |
| 1. What time do you get out of bed in the mornings?
 |  |
| 1. What is the biggest source of stress in your life?
 | Personal\_\_\_ Professional\_\_\_  |
| Summarize: |
| 1. Have you ever been treated for clinical depression?
 | Yes\_\_\_ No\_\_\_ |
| If yes, when? |

**D. Diet Assessment**

|  |  |
| --- | --- |
| 1. Do you tend to eat everything on your plate?
 | Yes\_\_\_ No\_\_\_ |
| 1. How many meals per day do you eat including snacks?
 |  |
| 1. Have you ever kept a food journal?
 | Yes\_\_\_ No\_\_\_ |
| 1. Do you eat breakfast?
 | Yes\_\_\_ No\_\_\_ |
| 1. Have you ever participated in a fad diet (Atkins for example)?
 | Yes\_\_\_ No\_\_\_ |
| 1. Do you take vitamin supplements?
 | Yes\_\_\_ No\_\_\_ |
| 1. Do you typically have dessert after a meal?
 | Yes\_\_\_ No\_\_\_ |
| 1. What typically is the most sluggish part of your day?
 | Early afternoon\_\_\_Late afternoon\_\_\_ None\_\_\_ |
| 1. List any foods you are allergic to:
 | Yes\_\_\_ No\_\_\_ |
| 1. Do you drink alcohol?
 | Yes\_\_\_ No\_\_\_ |
| 1. If yes, how many times per week?
 | 1-2\_\_\_ 3-4\_\_\_ Everyday\_\_\_ |
| 1. How many times per week do you eat processed foods?
 | 1-2\_\_\_ 3-4\_\_\_ Everyday\_\_\_ |
| 1. How often do you eat fast food?
 | 1-2 times per week\_\_\_ 3-4 times per week\_\_\_ 5 plus times per week\_\_\_\_ |

**E. Workout History**

|  |  |
| --- | --- |
| 1. When was your last workout?
 |  |
| 1. Have you ever worked with a personal trainer?
 | Yes\_\_\_ No\_\_\_ |
| 1. Have you ever experienced dizziness, light-headedness or a rapid heartbeat while working out
 | Yes\_\_\_ No\_\_\_ |
| 1. Have you ever been injured while working out?
 | Yes\_\_\_ No\_\_\_ |
| If yes, describe. |
| 1. Do you have any physical limitations that would prevent you from conducting exercise?
 | Yes\_\_\_ No\_\_\_ |
| If yes, please describe. |
| 1. Are you currently taking any medications that may adversely affect your training experience? (For example slow down or speed up your heart rate)
 | Yes\_\_\_ No\_\_\_ |
| 1. Have you ever experienced any of the following: presence of weakness, fatigue, fever, chills, night sweats, recent changes in sleep habits, daytime sleepiness, edema and/or abnormal swelling on any areas of your body?:
 | Yes\_\_\_ No\_\_\_ |

**F. Motivation**

|  |
| --- |
| 1. What makes you motivated the most to change?
 |
| During social interactions:\_\_\_ When getting dressed\_\_\_ Work performance\_\_\_ |
| During physical activities: \_\_\_ Low energy level\_\_\_ Low self-image\_\_\_ |
| 1. What was the heaviest you have ever weighed and when?
 |  |
| 1. What was the primary source behind your weight gain?
 | Financial stress\_\_\_ Grief and Recovery\_\_\_Work-related \_\_\_ Family\_\_\_ NA\_\_\_ |
| 1. What upcoming event in your life will help you to get and stay motivated?
 | Birthday\_\_\_ Cruise\_\_\_ Wedding\_\_\_ Athletic Event\_\_\_ Better Person\_\_\_ |
| 1. Which part of your body do you most wish to change?
 | Stomach\_\_\_ Legs/Butt\_\_\_ Arms\_\_\_ Chest/Back\_\_\_ |
| 1. What is your biggest challenge in staying on point?
 | Portion control\_\_\_ Number of meals\_\_\_ Social eating\_\_\_ Selection discipline\_\_\_ Late-evening munching \_\_\_ Exercise\_\_\_Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 1. What are your work hours and days off?
 |  |

**On a scale of 1-10 rate your overall motivation for getting fit:**

**1-2-3-4-5-6-7-8-9-10**

**Please summarize your overall fitness goal:**

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**Release and Waiver of Liability**

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**Participant Initials**

**Date:**