*Lifestyle Assessment Questionnaire*

# Infinite Strategies Coaching

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| Client Name: |  | Date: |  |

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

**A. Vital Statistics:**

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| --- | --- | --- | --- | --- | --- | --- | --- |
| 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**

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| --- | --- | --- |
| 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**

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| --- | --- |
| 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**

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| --- | --- |
| 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**

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| --- | --- | --- |
| 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**

Participant acknowledgment and assumption of risk and full release from liability of ***INFINITESTRATEGIES LLC/PWECMINSTRIES****.* Participant acknowledges that the Personal Training/Fitness Assessment/Boot Camp/Walking Club hereunder includes participation in strenuous physical activities, including but not limited to aerobic, weight training, various aerobic and conditioning activities, various nutritional programs offered by ***INFINITESTRATEGIESLLC/PWECMINISTRIES****.* Participant acknowledges that these physical activities involve inherent risk of physical injuries or other damages, including but not limited to heart attacks, muscle strains, pull or tears, broken bones, shin splints, heel prostration, knee/lower back/foot injuries and other illness, muscle soreness, or injury however caused, occurring during or after the participants participation in the physical activities. Participants acknowledge that such risks include but are not limited to injuries caused by the negligence of the instructor or other person, defective or improperly used equipment, over exertion, slip and fall or unknown health problem of a participant. Participant agrees to assume all risk and responsibility involved with participation in the physical activities. Participant, on behalf of participant his or her heirs, assigns and next of kin, agrees to fully release ***INFINITESTRATEGIESLLC/PWECMINISTRIES.*** from all liability, claims and/or litigation actions that participant may have for injuries disability or death or other damages of any kind, including but not limited to punitive damages, arising out of participation in ***INFINITESTRATEGIES LLC/PWECMINISTRIES.*** physical activities even if caused by the negligence, gross negligence, intentional acts, or omissions and/or any other type of fault of ***INFINITESTRATEGIESLLC/PWECMINISTRIES.***, its owners, employees, or authorized agents, including independent contractors.

**Participant Initials**

**Date:**