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NEW Training Health Questionnaire

General Information:

Name:_____ Today's Date:_____
Occupation (FT or PT):_____ Average Hours/Week_____
Address:_____
Phone:_____ Phone#2:_____ Email:_____
Age:_____ Date of Birth:_____ Gender:_____
Reason for Appointment:_____
_____
Primary Care Provider:_____
Address/Phone:_____
_____
Therapist:_____
Address/Phone:_____
_____
Education Level: Grammar School High School College Graduate School
Marital Status: Single Married Divorced Separated Widowed
Number of Children:_____ Ages:_____
Emergency Contact:
Name:_____ Relationship:_____
Home Number: ( ) _____ Cell Number: ( ) _____

Health History

Height:_____ Current Weight:_____ How Long at this Weight:_____

Please indicate whether you or a family member have/had any of the following conditions:

Disease/Condition	Self	Family	Relationship	Treatment
Asthma	_	_	_____	_____
Cancer	_	_	_____	_____
Cardiovascular Disease	_	_	_____	_____
Diabetes	_	_	_____	_____
Drug Dependency	_	_	_____	_____
Eating Disorder	_	_	_____	_____
Food Allergies	_	_	_____	_____
Food Intolerances	_	_	_____	_____
Kidney Disease	_	_	_____	_____
Headaches	_	_	_____	_____
Heart Attack	_	_	_____	_____
High Cholesterol	_	_	_____	_____

	Self	Family	Relationship	Treatment
Hypertension				
Intestinal Problems				
Menstrual Problems				
Mental Health Issues				
Obesity				
Osteoporosis				

Please list any previous injuries/surgeries/pain which may affect exercise:

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____

Are you currently being treated for any medical condition? Yes_ _ No_ _

If yes, please specify:_____

List any medications you are currently taken or have taken in the last year:

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____
7. _____ 8. _____
9. _____10. _____

Are you currently taking any food or nutritional/herbal supplements? Yes_ _ No_ _

If yes, please specify (Supplement Type and Brand):

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____
7. _____ 8. _____
9. _____10. _____

Have you ever been advised by your physician to follow a special diet? Yes_ _ No_ _

If yes, please specify:

_____

_____

_____

Are you currently follow that diet? Yes_ _ No_ _

If not, why? If yes, what changes have you made?_____

_____

_____

_____

Do you drink alcohol? Yes_ _ No_ _ Number of drinks per week:_____

Do you smoke cigarettes? Yes_ _ No_ _ Amount per day:_____

How long have you smoked? _____ If you quit smoking, when? _____

Do you use drugs? Yes_ _ No_ _ Explain: _____

_____

How many glasses of water do you drink per day? _____

Do you drink coffee, green tea, soda, iced tea? If yes, how much and what kind/s? _____

_____

Number of bowel movements daily?_____ If not daily, how frequent?_____

Menstrual History: (Female Client):

Are you currently menstruating? Yes_ _ No_ _ Have never menstruated? Yes_ _ No_ __

At what age did you get your first period? _____

Are you taking birth control/estrogen pills? Yes_ _ No_ _

Menstrual History (contd.)
Does your weight fluctuate during your period? Yes__ _ No__ ___
If yes, how many pounds?_____
Are your periods regular? Yes_ _ No_
Do you experience PMS? Yes_ _ No_
If yes, what are your symptoms? _____

Sleep/Rest:
On average, how many hours of sleep do you have each night? _____
Typical sleep cycle: Time you go to bed?_____ Time you wake up?_____
What time do you lay in bed?_____ When do you actually fall asleep?_____
Is your sleep **uninterrupted**? Yes No
If no, why?_____
_____

Stress:
What is your current stress level? (1 = extremely low, 5 = extremely high)

1 2 3 4 5

What are 3 main causes of your stress?

1._____

2._____

3._____

GOALS

Amount of weight you would be happy to lose in the first week (if applicable):_____

Ultimate goal weight:_____

Please write down your primary health/exercise/nutrition goal/s for the next:

- 1 month:_____
- 6 months:_____
- 1 year:_____

Rate the importance of each of the following exercise benefits to you (1-10. 1-not important. 10- very important)

___ Improve cardiovascular fitness
___ Increase muscular strength
___ Body fat/weight loss
___ Reshape or tone my body
___ Improve performance for a specific sport
___ Improve mood/feel better
___ Improve speed, agility, and power
___ Other _____

___Improve flexibility
___Improve balance
___Increase energy
___Decrease stress
___Enjoyment
___Social interaction

STOP!

THIS IS THE *EXERCISE* SECTION. PLEASE FILL OUT IF APPLICABLE

Have you had a personal trainer in the past? Yes_ _ No_ _
Did you train at home or at a gym? _____

What did you like most about working with him/her?_____

What did you like least about working with him/her?_____

What would you like to accomplish through your fitness program with me?

_____
_____
_____

Aside from technical knowledge and personal attention, what type of motivation do you require and expect from a trainer?

_____
_____
_____

What can we do together to make your exercise program more enjoyable?

_____
_____
_____

Do you own exercise equipment or accessories? (Please list):

_____
_____

Do you have access to a fitness facility? Yes_ _ No_ _

What are you current leisure activities?

_____
_____
_____

Please rate your exercise level on a scale of 1 – 5 (5 being very strenuous) for each age range throughout your life up through your present age range:

_____13-20 _____21-30 _____31-40 _____41-50 _____50+

Were you (or are you) a high school or college athlete? If yes, please specify:

_____

Do you have negative feelings toward, or have you ever had a bad experience with, a physical activity program? If yes, please explain:_____

Exercise (contd.)

Rate yourself on a scale of 1-5 (1 being the lowest value). Check the box number that best applies:

Characterize your present overall athletic ability.

☐1 ☐2 ☐3 ☐4 ☐5

Characterize your present cardiovascular (aerobic) activity.

☐1 ☐2 ☐3 ☐4 ☐5

Characterize your present muscular capacity (strength).

☐1 ☐2 ☐3 ☐4 ☐5

Characterize your present flexibility.

☐1 ☐2 ☐3 ☐4 ☐5

When you exercise, how important is competition?

☐1 ☐2 ☐3 ☐4 ☐5

Do you start exercise programs but then find yourself unable to stick with them? Yes_ _ No_____

If yes, please describe typical barriers: _____

_____

What days and times are most convenient for exercise?

Time	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

How much time, realistically, are you willing to devote to an exercise program?

_____ minutes per day _____days per week

Are you currently involved in regular cardiovascular exercise? Yes_ _ No_____

If yes, what type and how often? Types: _____

_____Minutes per day _____days per week

If applicable, rate your perception of the exertion of your current exercise program:

☐Light ☐Fairly Light ☐Somewhat Hard ☐Hard

How long have you been exercising regularly? Months_____ Years_____

What types of exercise interest you? Check all that apply.

☐Treadmill walking ☐Outdoor walking ☐Treadmill running
☐Outdoor running ☐Hiking ☐Swimming
☐Tennis ☐Stationary biking ☐Outdoor biking
☐Strength training ☐Martial arts ☐Yoga/Pilates
☐Spinning classes ☐Step classes ☐Cardio kickboxing
☐Other classes ☐Racquetball ☐Stairclimber
☐Elliptical machine ☐Other_____

Physical Activity Readiness
Questionnaire - PAR-Q

PAR-Q

Regular physical activity is fun and healthy, and increasingly more people are starting to become more active every day. Being more active is very safe for most people. However, some people should check with their doctor before they start becoming much more physically active.

If you are planning to become much more physically active than you are now, start by answering the seven questions in the box below. The PAR-Q will tell you if you should check with your doctor before you start. If you are over 69 years of age, and you are not used to being very active, check with your doctor.

Common sense is your best guide when you answer these questions. Please read the questions carefully and answer each one honestly: check YES or NO.

YES	NO	
☐	☐	**1. Has your doctor ever said that you have a heart condition and that you should only do physical activity recommended by a doctor?**
☐	☐	**2. Do you feel pain in your chest when you do physical activity?**
☐	☐	**3. In the past month, have you had chest pain when you were not doing physical activity?**
☐	☐	**4. Do you lose your balance because of dizziness or do you ever lose consciousness?**
☐	☐	**5. Do you have a bone or joint problem (for example, back, knee or hip) that could be made worse by a change in your physical activity?**
☐	☐	**6. Is your doctor currently prescribing drugs (for example, water pills) for your blood pressure or heart con-dition?**
☐	☐	**7. Do you know of any other reason why you should not do physical activity?**

If you answered

YES to one or more questions, please read and initial in box

Talk with your doctor by phone or in person BEFORE you start becoming much more physically active or BEFORE you have a fitness appraisal. Tell your doctor about the PAR-Q and which questions you answered YES.

- You may be able to do any activity you want — as long as you start slowly and build up gradually. Or, you may need to restrict your activities to those which are safe for you. Talk with your doctor about the kinds of activities you wish to participate in and follow his/her advice.
- Find out which community programs are safe and helpful for you.

Initial (if YES to any question) _____

NO to all questions

If you answered NO honestly to all PAR-Q questions, you can be reasonably sure that you can:

- start becoming much more physically active – begin slowly and build up gradually. This is the safest and easiest way to go.
- take part in a fitness appraisal – this is an excellent way to determine your basic fitness so that you can plan the best way for you to live actively. It is also highly recommended that you have your blood pressure evaluated. If your reading is over 144/94, talk with your doctor before you start becoming much more physically active.

DELAY BECOMING MUCH MORE ACTIVE:

- if you are not feeling well because of a temporary illness such as a cold or a fever – wait until you feel better; or
- if you are or may be pregnant – talk to your doctor before you start becoming more active.

PLEASE NOTE: If your health changes so that you then answer YES to any of the above questions, tell your fitness or health professional. Ask whether you should change your physical activity plan.

"I have read, understood and completed this questionnaire. Any questions I had were answered to my full satisfaction."

Name _____ Date _____

Signature _____ Date _____

Parent/Guardian Signature (if under 18 years old) _____ Date _____

Note: This physical activity clearance is valid for a maximum of 12 months from the date it is completed and becomes invalid if your condition changes so that you would answer YES to any of the seven questions.

Medical Release Form

- **If you answered "yes" to any of the questions on the PAR-Q form, it is required that you have a medical release completed by your physician before a trainer begins any fitness regimen with you.**
- **Your trainer may also require that a Medical Release Form be completed before beginning any fitness regimen with you if your health history indicates any higher risk conditions. If necessary, this will be discussed in greater detail during your initial consultation.**

Dear Doctor:

Your patient,_____, wishes to start a personalized fitness program with NEW TRAINING, LLC.

The activity will involve but is not limited to: regular cardiorespiratory activity and regular resistance training which will elevate his/her heart rate and blood pressure.

If your patient is taking medication that will affect his/her heart rate response to exercise, please indicate the manner of the effect (raises, lowers, or has no effect on heart-rate response):

Type of medication(s)_____

Effect(s)_____

Please identify any other recommendations or restrictions for your patient in this exercise program:

_____

_____

_____

_____(Clients full name) has my approval to begin an exercise program with the recommendations or restrictions stated above.

Printed name_____Phone_____

Signed_____Date _____

<u>DON'T FORGET TO READ AND SIGN PAGES 14 AND 15!</u>

STOP!

THIS IS THE *NUTRITION* SECTION. PLEASE FILL OUT IF APPLICABLE

Weight/Dieting History:

Have you tried to lose weight in the past? Yes_ _ No_

How many times? _____ Age of first attempt: _____

What did you do? _____

Why did you go on that diet? _____

_____

Have you ever use any of the following for weight control? If yes, please explain.

Commercial diet programs	Yes_	_ No_	_____
Liquid diets	Yes_	_ No_	_____
Fad diets	Yes_	_ No_	_____
Prescription diet pills	Yes_	_ No_	_____
Over-the-counter diet pills	Yes_	_ No_	_____
Laxatives	Yes_	_ No_	_____
Diuretics	Yes_	_ No_	_____
Ipecac Syrup	Yes_	_ No_	_____
Vomiting	Yes_	_ No_	_____
Self-designed program	Yes_	_ No_	_____

Other _____

Do you experience periods during which you eat uncontrollably? Yes_ _ No_

If yes, how often? _____

At what age did this begin? _____

Is this followed by:

_____ Vomiting	Age began:_____	How often?	_____
_____ Laxative use	Age began:_____	How often?	_____
_____ Excessive exercising	Age began:_____	How often?	_____
_____Negative emotions	Age began:_____	How often?	_____

_____Other _____

Have you ever been diagnosed with an eating disorder? Yes_ _ No_

If yes, please explain: _____

Are you currently or have you ever received treatment? Yes_ _ No_

If yes, please explain: _____

Family Weight History:

Are any members of your family overweight? Yes_ _ No_

Please explain:_____

Are any members of your family underweight? Yes_ _ No_

Please explain:_____

Does anyone in your family diet? Yes_ _ No_

Please explain:_____

Did/Does anyone in your family have an eating disorder? Yes_ _ No_

Please explain:_____

Does your family eat meals together? Yes_ _ No_

What meals?_____

What is this like?_____

Eating Habits:

Do you skip meals? Yes_ _ No_ _

How many days per week do you eat:

Breakfast:_____ Lunch:_____ Dinner:_____

Do you snack? Yes_ _ No_ _

If so, when?_____

Do you buy or pack your lunches?

Buy_____ # days per week:_____

Pack_____ # days per week:_____

Do you eat out? Yes_ _ No_ _

How many meals per week do you eat out? _____

What restaurants do you usually choose?_____

Who usually prepares the food at home?_____

Do you know how to cook? Yes_ _ No_ _

Who does the grocery shopping?_____

Do you read food labels? Yes_ _ No_ _

What do you look at on the label?_____

Do the nutrition facts influence your decision to eat the food? Yes_ _ No_ _

Do you eat standing up? Yes_ _ No_ _

Do you eat in the car? Yes_ _ No_ _

Do you eat while watching TV? Yes_ _ No_ _

Do you eat while reading or on the computer? Yes_ _ No_ _

Do you eat with others? Yes_ _ No_ _

Do you eat fast? Yes_ _ No_ _

Do you eat when bored? Yes_ _ No_ _

Do you eat when stressed? Yes_ _ No_ _

Do you eat when anxious? Yes_ _ No_ _

Do you eat when lonely? Yes_ _ No_ _

Do you eat when hungry? Yes_ _ No_ _

Do you eat when not hungry? Yes_ _ No_ _

Do you avoid certain foods? Yes_ _ No_____

If yes, please specify:_____

What are your favorite foods?_____

Malnutrition Symptoms:

Do you now or have you ever experienced (for each check, please add explanation):

_____Irregular menstrual periods _____

_____Absent menstrual periods _____

_____Cold Intolerance _____

_____Tingling sensation in hands or feet _____

_____Headaches _____

_____Lightheadedness/Dizziness _____

_____Fainting _____

_____Sleeping Difficulties _____

_____Skin Changes _____

_____Hair loss _____
_____Hair growth on face and/or chest _____
_____Chest Pains _____
_____Rapid heart beat _____
_____Shortness of breath _____
_____Mood Swings _____
_____Episodes of crying for “no reason” _____
_____Frequently thinking about food _____
_____Confusion _____
_____Difficulty concentrating _____
_____Anxiety, especially around food _____
_____Less social interaction with family _____
_____Frequently tired _____
_____Memory problems _____
_____Difficulty making decisions _____
_____Problems with teeth or gums _____
_____Sore throat _____
_____Swollen parotid glands _____
_____Taste changes _____
_____Constipation _____
_____Diarrhea _____
_____Muscle Pain/Weakness _____
_____Joint Pain _____
_____Obsessive-compulsive behaviors _____
_____Other (explain)_____

Why do you want to change your eating habits? _____
_____
_____

List 3 Nutritional Goals:

1. _____
2. _____
3._____

Did you have any expectations from coming to see the dietitian today? Yes_ _ No_ _
Please explain:_____

YOU ARE ALMOST DONE!
THE PAGES BELOW SHOULD BE FILLED OUT WITH GREAT ACCURACY. THIS WILL GIVE YOU THE MOST PERSONALIZED NUTRITION PLAN POSSIBLE.

Food Frequency Checklist

Type X for the frequency the following foods are consumed	Never or less than once per week	1-2 times per week	3-7 times per week	More than once per day
Beef				
Sausage, Bacon, Lunchmeat				
Pork				
Poultry				
Breaded Poultry (i.e. nuggets)				
Fried Poultry				
Fish				
Breaded Fish (i.e. fish sticks)				
Fried Fish				
Shellfish				
Beans				
Peanut Butter				
Pizza				
Milk (which %)				
Cream				
Cheese				
Regular Cheese				
Low Fat Cheese				
Non-Fat Cheese				
Yogurt				
Ice Cream				
Frozen Yogurt				
Eggs				
Oils				
Butter				
Margarine				
Vegetables				
Fruits				
Fruit Juice				
Breads				
Cereals				
Pasta, noodles, rice, etc. (cup)				
Potatoes				
Commercial baked goods (cookies, donuts, cakes, etc.) (serving)				
Cookies				
Soft Drinks (non-diet) (serving)				
Snack crackers (serving)				
Nuts and Seeds (1/4 cup)				
Potato Chips or Corn Chips (cup)				
Sherberts and Ices (1/2 cup)				
Candy				
Frozen Meals				
Chinese Food				
Fast Food				
OTHER				
OTHER				
OTHER				
OTHER				
OTHER				

Food Likes & Dislikes

Food	Likes	Dislikes
Vegetables	*i.e. cauliflower*	*i.e. broccoli*
Fruits		
Pasta, Rice (egg noodles, macaroni, etc)		
Poultry (Chicken, Turkey, etc)		
Beef (steak, hamburger, etc)		
Dairy (cheese, eggs, milk, etc)		

DAILY FOOD AND EXERCISE LOG

Time of Day	Amount of Food	Type of Food or Beverage	How was it prepared?	How did you feel after you ate or drank? (Examples: Full? Bloated? Tired? Satisfied?)
	WHAT TIME DO YOU WAKE UP?			

EXERCISE

TIME	DURATION	DESCRIPTION

DON'T FORGET TO READ AND SIGN PAGES 14 AND 15!

Licensed Registered Dietitian and Certified Personal Trainer

Participant Release and Knowledge of Agreement

1. I, the undersigned participant, am hereby enrolling in a program of strenuous physical activity and/or nutrition and diet consultation offered by Joseph Champa d/b/a "N.E.W. Training" (hereinafter referred to as "N.E.W. Training").

2. I have been strongly encouraged to consult with my physician prior to starting an exercise program or increasing the intensity of an existing program both in this document and by N.E.W. Training. I assume this responsibility as indicated by my below signature and if I chose to, will act on this advice prior to the implementation of any recommendations made by N.E.W. Training.

3. I hereby affirm that, to the best of my knowledge, I do not suffer from any condition that would prevent or limit my participation in this Fitness and/or Nutrition Program and have not withheld any related information from N.E.W.Training. Or, in the event that through screening, I have been determined to be other than apparently healthy, I have been given a physician's release, as required by N.E.W.Training. I am taking no medications that may adversely affect my fitness or diet activities, and this release, with or without physician's restrictions, has been given to N.E.W.Training.

4. In addition, I acknowledge that if my health changes, it is my responsibility to recognize the change and seek medical advice to help me decide if my continued participation in the Fitness and/or Nutrition Program or any part of the Fitness and/or Nutrition Program is still right for me.

5. I hereby assume all risks associated with consuming any foods or nutritional supplements offered by N.E.W. Training, such as food allergies or health problems that require special diets. It is with my understanding that I should seek my doctor's advice before accepting such foods or nutritional supplements.

6. I hereby release N.E.W.Training, and its agents, from any liability now or in the future for any injury, including, but not limited to heart attacks, death, muscle strains, pulls or tears, broken bones, shin splints, heat prostration, knee/lower back/foot injuries and any other illness, soreness or injury however caused, unless caused by the trainer's recklessness or intentional misconduct.

7. I also understand that Joseph Champa is not a physician and the scope of his consultation services does not include treatment or diagnosis of specific illnesses or disorders.

8. I am aware that rather than dealing with the treatment of disease, N.E.W. Training Nutrition focuses on wellness and prevention of illness through the use of exercise and nutrition to achieve optimal health. While people generally experience greater health and wellness as a result of embracing a healthier attitude, lifestyle, and diet, N.E.W. Training does not promise or guarantee protection from future illness.

9. In consideration of my participation in N.E.W.Training Fitness and/or Nutrition Program, I, for myself, my personal representatives, administrators, heirs and assigns, hereby holds harmless N.E.W.Training, and its agents, from any claims, demands, and causes of action, including reasonable legal expenses and attorney's fees, arising from my participation in the Fitness and/or Nutrition Program unless caused by the trainer's recklessness or intentional misconduct.

10. I understand that N.E.W. Training requires that I provide 24 hours notice when cancelling an appointment. No charge will be levied should I cancel with MORE than 24 hours notice given. Should I cancel a session with LESS than 24 hours prior notice, N.E.W. Training may, at its option, charge me in full for that session. Waiver of this option by N.E.W. Training does not predicate any such future waivers. I understand that N.E.W. Training recommends that all cancelled sessions be rescheduled to ensure consistency and fitness progress.

11. I hereby affirm that I have read, have been honest with N.E.W.Training, and fully understand the above information. I have been given the opportunity to present questions in all related matters.

_____

CLIENT

_____

DATE