



South Riding Wellness Connection

A balanced approach to mental, physical, and spiritual health

Health History/Life Style Information Form

Name: _____ Date: _____

Phone: _____ Email: _____ Age: _____

Emergency Contact Person: _____ Emergency contact Phone: _____

Do you now, or have you had in the past:

- | | Yes | No |
|--|--------------------------|--------------------------|
| 1. History of heart problems, chest pain, or stroke | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Increased blood pressure | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Any chronic illness or condition | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Difficulty with physical exercise | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Advice from physician not to exercise | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Recent surgery (last 12 months) | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Pregnancy (now or within last 3 months) | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. History of breathing or lung problems | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Muscle, joint, or back pain, or any previous injury still affecting you | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Experience frequent headaches or dizziness | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Cigarette smoking habit | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Obesity (more than 20% over ideal body weight) | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. High cholesterol or diabetes | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Please explain any "yes" answers. | | |

Fitness Assessment and Lifestyle Information

What is your present occupation? _____

Does your occupation require much activity (i.e. walking, getting up or down, carrying things)?

In the past year, how often have you been engaged in physical activity?

___ Regularly (3 to 4 times/week) ___ Semi-regular (1 to 2 times/week)

___ Sporadic (1 to 2 times/month) ___ Not at all

List physical activities you have participated in the past:

What is your main goal for exercising? (check any that apply)

- | | |
|--|--|
| <input type="checkbox"/> Weight loss/burn fat | <input type="checkbox"/> Feel better in my clothes |
| <input type="checkbox"/> Building strength/muscles | <input type="checkbox"/> Increase cardio performance |
| <input type="checkbox"/> Lower cholesterol/BP | <input type="checkbox"/> Overall health |

What are your personal barriers to exercise (i.e. your reason for not exercising)?

Describe what you would like to accomplish through your fitness program: (i.e. in six months time how would you ideally like to describe your body, physical vitality or performance):

Dietary Patterns:

Do you feel you eat healthy?

- Most of the time Sporadically Hardly at all

What would you estimate your caloric intake to be per day? _____

How many meals and/or snacks do you have per day? _____

How often do you eat (i.e. every 4 hours)? _____

How often do you “go on a diet”?

- | | |
|---|---|
| <input type="checkbox"/> Start a new one every week | <input type="checkbox"/> New one every few months |
| <input type="checkbox"/> Only on rare occasions | <input type="checkbox"/> Never |

What barriers if any keep you from maintaining a healthy eating plan? (i.e. job/family stress, too busy, overeat for emotional reasons, just enjoy “junk food”)
