YOURBeFitLIFE
Program Designer and Coach:
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yourbefitlife.com 619.865.7667

DATE: _____
NAME: _____
PHONE: _____
EMAIL: _____
BIRTHDATE: _____ AGE: _____

YOUR KICK-START Questionnaire

please print* and complete ***prior*** to your initial coaching session.
**if you can not print, contact us (rhonda@yourbefitlife.com) for a paper copy.*

1. Have you had to see a doctor in the past three years for any bone, joint, or spine problems?
   □ No
   □ One or two visits, but no problems now
   □ Do doctors give frequent-flyer miles?

2. Have you ever had an orthopedic injury severe enough to result in one of the following?
   • Kept you out of sports or exercise for a month? □ No □ Yes
   • Required crutches for two or more weeks?
   □ No □ Yes
   • Required surgery?
   □ No □ Yes

3. Have you ever dislocated or separated your shoulder? □ No □ Yes
   If yes, please explain: _____
   _____
   _____

4. Do you have joint swelling?
   □ No □ Yes

5. Have you lost mobility (range of motion) in any joint? For example, can you fully straighten (extend) and fully bend (flex)? Compare right side to left side.
   □ No
   □ A little stiff at times, but motion is full
   □ Motion is limited in one or two major joints or the spine. If so, please specify:

6. Do you have stiffness in any joints associated with any of the following conditions?
   • Upon awakening (i.e., until showering or moving for about 15–20 minutes)
   □ No
   □ Only the day after a hard workout
   □ Yes
   • After sitting still for more than 30 minutes
   □ No
   □ Only the day after a hard workout
   □ Yes
   • For no apparent reason
   □ No
   □ Only the day after a hard workout

7. Do your knees creak or make noise when you are going up or down stairs?
   □ No
   □ Yes, but no discomfort or pain
   □ Yes, and does cause discomfort and/or pain

8. Do you have trouble actually ascending or descending stairs? □
   No □
   Only after going up and down multiple times, especially while carrying heavier items

9. Does high barometric pressure (i.e., damp, rainy weather) make your joints ache?
   □ No
   □ Rarely
   □ Friends consult me instead of the weatherman

YOUR Body History cont …

10. Have you ever had an episode of lower-back or neck pain or spasm?
□ No
□ Yes, it kept me off my feet for less than 24 hours
□ Yes, I miss work due to recurrent episodes

11. Do you have pain while lying on either shoulder at night in bed?
□ No
□ Rarely
□ Almost nightly; tossing and turning to get comfy

12. Do you have difficulty falling asleep at night or awaken during the night because of any joint or muscle discomfort?
□ No
□ Rarely or minor difficulty
□ Yes

13. Do you awaken at night with your hands or fingers "asleep"?
□ No
□ Rarely and I easily shake it off
□ My hands get more sleep than I do

Note: If "Yes" to any, 1 -13, this may suggest a musculoskeletal issue that may warrant further evaluation by healthcare professional.

YOUR Exercise History

1. Please rate your exercise level on a scale of 1 to 5 (5 indicating very strenuous) for each age range through your present age: 15–20 _____ 21–30 _____ 31–40 _____ 41–50 _____ 51+_____

2. Were you a high school and/or college athlete?
□ Yes □ No If yes, please specify _____

_____

3. Do you have any negative feelings toward, or have you had any bad experience with, physical-activity programs?
□ Yes □ No If yes, please explain _____

_____

4. Do you have any negative feelings toward, or have you had any bad experience with, fitness testing or evaluation?
□ Yes □ No If yes, please explain _____

_____

5. Please rate yourself on a scale of **1 to 5** *(1 indicating the lowest value and 5 the highest).*

Characterize your present athletic ability. 1 2 3 4 5

When you exercise, how important is competition? 1 2 3 4 5

Characterize your present cardiovascular capacity. 1 2 3 4 5

Characterize your present muscular capacity. 1 2 3 4 5

Characterize your present flexibility capacity. 1 2 3 4 5

YOUR Exercise History cont…

6. Do you start exercise programs but then find yourself unable to stick with them? □ Yes □ No

7. How much time are you willing to devote to an exercise program? _____ minutes/day

8. Are you currently involved in regular endurance (cardiovascular) exercise? □ Yes □ No

If yes, specify the type of workouts/exercise(s):

1 _____ _____ minutes/day _____ days/week

2 _____ _____ minutes/day _____ days/week

3 _____ _____ minutes/day _____ days/week

4 _____ _____ minutes/day _____ days/week

5 _____ _____ minutes/day _____ days/week

6 _____ _____ minutes/day _____ days/week

7 _____ _____ minutes/day _____ days/week

8 _____ _____ minutes/day _____ days/week

Rate your perception of the exertion of your workout/exercise from above (check the box):

1 □ Light □ Fairly light □ Somewhat hard □ Hard Notes: _____

2 □ Light □ Fairly light □ Somewhat hard □ Hard Notes: _____

3 □ Light □ Fairly light □ Somewhat hard □ Hard Notes: _____

4 □ Light □ Fairly light □ Somewhat hard □ Hard Notes: _____

5 □ Light □ Fairly light □ Somewhat hard □ Hard Notes: _____

6 □ Light □ Fairly light □ Somewhat hard □ Hard Notes: _____

7 □ Light □ Fairly light □ Somewhat hard □ Hard Notes: _____

8 □ Light □ Fairly light □ Somewhat hard □ Hard Notes: _____

9. What other exercise, sport, or recreational activities have you participated in?

In the past 6 months? _____

In the past 5 years? _____

YOUR Exercise History cont…

10. How long have you been exercising regularly?_____ months _____ years

11. Can you exercise during your work day? □ Yes □ No

12. Would an exercise program interfere with your job? □ Yes □ No

13. Would an exercise program benefit your job? □ Yes □ No

14. What types of exercise interest you? □ Walking □ Jogging □ Aerobics □ Strength training

□ Racquetball □ Tennis □ Golf □ Kettlebells □ Stationary Bike □ Cycling □ Rowing

□ Yoga □ Pilates □ Stretching □ Circuit Training □ Other: _____

15. Rank your goals (1 *low importance* - 10 *high importance*) in undertaking exercise: What do you want exercise to do for you? Please use the following scale to rate each goal separately.

a. Improve cardiovascular fitness
b. Facilitate body-fat weight loss
c. Reshape or tone my body
d. Improve performance for a specific sport
e. Improve moods and ability to cope with stress
f. Improve flexibility
g. Increase strength
h. Increase energy level
i. Feel better
j Increase enjoyment

Other? _____

16. By how much would you like to change your current weight? (+) _____ lb or (–) _____

17. Current Weight _____. Highest weight _____ and lowest weight _____ in past 5 years.

Please answer yes or no:	Y	N
Are you looking to change a specific behavior?	□	□
Are you willing to make this behavioral change a top priority?	□	□
Have you tried to change this behavior before?	□	□
Do you believe there are inherent risks/dangers associated with not making this behavioral change?	□	□
Are you committed to making this change, even though it may prove challenging?	□	□
Do you have support for making this change from friends, family, and loved ones?	□	□
Besides health reasons, do you have other reasons for wanting to change this behavior?	□	□
Are you prepared to be patient with yourself if you encounter obstacles, barriers, and/or setbacks?	□	□

YOUR Health History

MEDICAL INFORMATION

1. How would you describe your present state of health?

   □ very well □ healthy □ unhealthy □ ill □ other:_____

2. Are you taking any prescription medication? □ Yes □ No
   If yes, what medications and why?

   Medication: _____ Why: _____

   Does it interact with foods or weight loss in any way? _____

   Medication: _____ Why: _____

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   Medication: _____ Why: _____

   Does it interact with foods or weight loss in any way? _____

   Medication: _____ Why: _____

   Does it interact with foods or weight loss in any way? _____

   Medication: _____ Why: _____

   Does it interact with foods or weight loss in any way? _____

3. Do you take any over-the-counter medication? □ Yes □ No
   If yes, what medications and why?

   Medication: _____ Why: _____

   Does it interact with foods or weight loss in any way? _____

   Medication: _____ Why: _____

   Does it interact with foods or weight loss in any way? _____

   Medication: _____ Why: _____

   Does it interact with foods or weight loss in any way? _____

   Medication: _____ Why: _____

YOUR Health History cont…

MEDICAL INFORMATION cont…

4. When was the last time you visited your physician? _____

5. Have you ever had your cholesterol checked? □ Yes □ No

   If yes, Date of test:_____ Do you know the results?

   Total Cholesterol: _____ [HDL:_____ LDL:_____] TG:_____
   NOTE: HDL = High-density lipoprotein; LDL = Low-density lipoprotein; TG = Triglycerides

   Have you ever had your blood sugar checked? □ Yes □ No

   If yes, do you know the results? _____ Pre-diabetic? □ Yes □ No

6. Please check any that apply to you and list any important information about your condition:

   □ Allergies (Specify:_____)
   □ Amenorrhea □ Anemia □ Anxiety □ Arthritis □ Asthma □ Celiac disease
   □ Chronic sinus condition □ Constipation □ Crohn's disease □ Depression
   □ Diabetes □ Diarrhea □ Disordered eating □ Gastro-esophageal reflux disease (GERD)
   □ High blood pressure □ Hypoglycemia □ Hypo/hyperthyroidism □ Insomnia
   □ Intestinal problems □ Irritability □ Irritable bowel syndrome (IBS) □ Menopausal symptoms
   □ Osteoporosis □ Premenstrual syndrome (PMS) □ Polycystic ovary syndrome (PCOS)
   □ Pregnant □ Pregnancy (how many? _____) □ Ulcer □ Skin problems

   □ Major surgeries: _____ , _____ , _____

   □ Past injuries: _____ , _____ , _____

   □ Describe any other health conditions that you have or have had (please include year):

   _____

   _____

   _____

   _____

8. Has anyone in your immediate family been diagnosed with the following?

   □ Heart disease □ High cholesterol □ High blood pressure
   □ Cancer □ Diabetes □ Osteoporosis

YOUR Health History cont…

DIETARY INFORMATION

9. What are your dietary goals? _____

_____

_____

10. Have you ever followed a modified diet(s)? □ Yes □ No

If so, please describe (all):_____

_____

_____

_____

11. Are you currently following a specialized diet (e.g., low-sodium or low-fat)? □ Yes □ No

If so, what type of diet? _____

_____

_____

Why did you choose this diet?_____
Was the diet prescribed by a physician? □ Yes □ No
How long have you been on the diet?_____ Do you like it? □ Yes □ No

12. Have you ever met with a registered dietitian? □ Yes □ No Reason: _____

Are you interested in meeting with one? □ Yes □ No Reason: _____

13. What do you consider to be the major issues in your diet and eating plan? (e.g., eating late at night, snacking on high-fat foods, skipping meals, or lack of variety) _____

_____

_____

14. How many glasses of water do you drink per day? _____ (measured as 8-ounce glasses)

15. Do you have any food allergies or intolerance? □ Yes □ No

If so, what?_____

YOUR Health History cont…

DIETARY INFORMATION cont….

16. Who prepares your food? □ Self □ Spouse □ Parent □ Minimal preparation □ Do not Cook

17. How often do you dine out? _____ times per week

18. Please specify the type of restaurants for each type of meal:

Breakfast:_____

Lunch: _____

Dinner:_____

Snacks: _____

19. Do you crave any foods? □ Yes □ No

If so, please specify:_____

_____

20. How is your appetite affected by stress? □ increased □ not affected □ decreased

21. Do you drink alcohol? □ Yes □ No

How often? _____times per week Average amount? _____glasses

22. Do you use tobacco? □ Yes □ No

How much (cigarettes, cigars, or chewing tobacco per day)?_____

23. Do you drink caffeinated beverages? □ Yes □ No

How often? _____times per week Average number per day:_____

24. Do you take any vitamin, mineral, or herbal supplements? □ Yes □ No

Please list type and amount per day (include all):

_____

_____

_____

YOUR Health History cont…

DIETARY INFORMATION cont….

16. Who prepares your food? □ Self □ Spouse □ Parent □ Minimal preparation □ Do not Cook

17. How often do you dine out? _____ times per week

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20. How is your appetite affected by stress? □ increased □ not affected □ decreased

21. Do you drink alcohol? □ Yes □ No

How often? _____times per week Average amount? _____glasses/day

22. Do you use tobacco? □ Yes □ No

How much (cigarettes, cigars, or chewing tobacco per day)?_____

23. Do you drink caffeinated beverages? □ Yes □ No

How often? _____times per week Average number per day:_____

24. Do you take any vitamin, mineral, protein, herbal, etc. supplements? □ Yes □ No

Please list type and amount per day (include all): One specific brand? _____

_____

_____

_____

THANK YOU for SHARING – We look forward to getting FIT with YOU!!