# H.E.A.L.T.H.

BY HOT SPRINGS HEALTH & FITNESS

Information Form:

Full Name: _____ Preferred email address_____

Cell Number: _____ DOB_____/_____/_____ Gender: Male Female

Occupation: _____

Name of Emergency Contact: _____ Best Phone Number: _____

Primary Care Doctor: _____ Primary Care phone number: _____

Current weight_____lbs Goal weight_____ lbs Ht: _____ft_____ in

How would you describe your overall, general Health: Excellent Good Average Fair Poor

Have you ever been diagnosed with any of the following:

| | Yes or No | | Yes or No |
|---|---|---|---|
| Type 1 DM | | Autoimmune disease | |
| Type 2 DM | | HYPOthyroidism | |
| Healing Problems/open wounds | | HYPERthyroidism | |
| Multiple Sclerosis | | Osteoporosis or osteopenia | |
| Neuropathy | | Osteoarthritis | |
| Fibromyalgia | | Rheumatic Arthritis | |
| Other soft tissue disorder | | PCOS/ endometriosis | |
| Hearing Impairment | | Infertility or other reproductive conditions | |
| Vision Impairment | | Uterine or bladder prolapse | |
| Developmental or Growth Irregularities | | Kidney disease, kidney stones or urinary conditions | |
| Asthma | | Allergies | |
| Emphysema/COPD | | Cancer | |
| Seizures/epilepsy | | Dementia | |
| Stroke/TIA | | Depression | |
| Vascular Disease | | Anxiety | |
| HYPERtension | | Mental illness | |
| HYPOtension | | Drug/alcohol dependency | |
| Dizziness or vertigo | | Artificial joints | |
| Pacemaker or stent | | Chronic constipation | |

| | | | |
|---|---|---|---|
| Angina or arrhythmia | | Ulcerative Colitis | |
| Heart disease | | Inflammatory Bowel Disease or Irritable Bowel Syndrome | |
| Celiac Disease | | Crohn's Disease | |
| Obesity | | Gait Imbalance | |
| Gastric or peptic ulcer disease | | Gerd, Reflux/heart burn | |
| Anemia | | Gout | |
| High Cholesterol | | Cerebral palsy | |
| Muscular dystrophy | | Gastroparesis | |
| Heart attack | | Migraines | |
| Sleep Apnea | | | |

Next 4 questions Females only:
Are you currently pregnant? Yes or No, How many weeks are you? _____
Are you currently on hormone replacement therapy, TRT pellets? Yes_____ NO___ If yes, what are you taking

_____
_____
Are you: Perimenopasual_____, post-menopausal_____, neither still menstruating_____
Do you experience menopausal symptoms?

_____
_____
_____

For any marked conditions above please share further details:

_____
_____
_____
_____
_____

Are there any other acute or chronic conditions you experience:

_____
_____
_____

Are you currently under the supervision of a physician for reason outside of regular PCP visits? If yes, please explain

_____
_____
_____
_____
Please list any past injuries, surgeries or hospitalizations

_____
_____
_____
_____

Please list any names of the current medication or supplements you are taking

_____

_____

_____

Have you needed to have or currently taking any regular Injections of Steroid Medication (prednisone, sol Medrol)? If yes, what are you taking? _____
Have you or are you taking any acid blocking drugs like Zantac, Pepcid?
Have you or are you taking any GLP 1 medications, such as Ozempic, semaglutide, wegovy, etc Yes ____ NO___
If yes, which one are you/have you taken_____, what was your results

_____
Check mark which of the following areas are you interested in gaining improvements in?

| | | | |
|---|---|---|---|
| Strength training | | Injury prevention | |
| mobility | | Injury rehabilitation | |
| Gait balance | | Sport specific conditioning | |
| Pain management | | Weight loss | |
| Healthy weight gain | | | |

Do you have a fitness watch or tracer (ex: Appel watch, garmin, polar)? Yes____ No____ if yes, what kind_____

How would you rate your exercise proficiency? Highly proficient Some exercise No experience Unsure

On a scale of 1-10, with 10 being highly motivated, how would you rate your current level of motivation as it related to your fitness and wellness goals? _____

Consent and Agreement to Participate in Health, Fitness, and Nutrition Program

I have been informed that I will perform various physical tests and activities designed to evaluate and positively enhance my health, fitness and wellness status. I certify that I am of sound cognizance and that I have provided complete and accurate responses to questions herein this intake form. I recognize risks associated with physical exercises do exist and that any withholding of information regarding my health history cold lead to possibly injury during these exercise and procedures. I agree to disclose any changes in my health status as these changes could lead to possible injury during these exercises and procedures. I agree to disclose any changes in my health status as these changes arise prior to any future sessions. **I understand that I am welcome to cease participation in physical exercise or training at any time without penalty**. *(QUESTION HERE ABOUT THIS WITH PROGRAM/ or should say with training and exercise testing)*
I understand that physical exercise training conducted with my personal trainer/strength and conditioning coach is for general wellness purpose and is not a substitute for medical examination, diagnosis or treatment. I understand that the trainer/coach reserves the right to determine the appropriate exercise and degree of intensity for each client.
Signature_____ Date_____

Physical Activity Readiness Questionnaire

Regular physical activity is fun and healthy, and increasingly more people are becoming more active every day. Bing 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 increase your activity level, start by answering the seven questions. If you are between the ages of 15 and 69, 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 before beginning new exercise regime

| Question | Yes | NO |
|---|---|---|

| | | |
|---|---|---|
| Has your doctor ever said that you have a heart or cardiovascular condition and that you should only do physical activity recommended by a doctor | | |
| Do you feel pain in your chest when you do physical activity | | |
| In the past mont, have you had chest pain when you were NOT doing physical activity | | |
| Do you lose your balance because of dizziness or do you ever lose consciousness? | | |
| Do you have a bone or joint problem that could be made worse by a change in your physical activity? | | |
| Is you doctor currently prescribing medication for your blood pressure or heart condition? | | |
| Do you know of any other health reason why you should enter into physical activity cautiously | | |

1. How would you rate your diet? Excellent_____ Good_____ Fair_____ Poor_____
2. My nutrition knowledge is: Very good_____ Good_____ Average_____ Not so good____ I want to learn more____
3. Have you ever had a consultation with a dietitian or nutritionist? Yes_____ No_____
4. Have you ever tried structured programs to lose weight? Yes____ No___ Were you successful? Yes, ___ No___ If yes, how much weight did you lose? _____ How long did you keep it off? _____
5. Do you have any food allergies? Yes_____ No_____ If yes, what are you allergic to?_____
6. Do you have any food intolerances or strong dislikes? Yes____ No_____
   If yes, to what specific foods?
   _____
7. How many meals do you eat per day?

   one meal _____ one to two meals _____

   two meals _____ two to three meals _____

   three meals _____ three or more meals_____

8. if you skip meals what meal(s) do you usually skip: breakfast ____ lunch ____ dinner_____
9. How many days a week do you skip this meal _____
10. I eat out for:

    Breakfast: rarely _____sometimes ___often _____daily____

    Lunch: rarely _____sometimes _____often _____daily_____

    Dinner: rarely _____sometimes _____often _____daily_____

11. Are your meals? large portion _____extra-large portions _____high fat ____high carbohydrate _____ high sugar _____
12. How often do you snack? a.m. snack _____p.m. snack _____evening snack _____ snack between all meals ____ grazing on food throughout the day_____
13. What beverages do you drink (please mark how many ounces you drink of each daily)
    Water _____ whole milk _____
    Diet soda _____ Regular soda _____
    Regular coffee _____Decaf coffee _____
    Regular tea _____ Decaf tea _____
    2% milk _____ 1% milk _____
    skim milk _____ juice _____
    sweet tea _____unsweetened tea
14. How often do you eat fast food or go to a restaurant?
    0-1/month_____ 2-3/month_____ 1-2/week_____ 3-4/week_____ 5+/week_____
15. How often do you drink alcohol?
    0-1/month____ 2-3/month_____1-2/week_____ 3-4/week _____5+/week_____
16. When you drink, on average, how many servings of alcohol do you drink in one sitting (1 serving = 12 oz beer, 5 oz wine, 1 oz liquor)? serving(s) If yes what type how much and how often.
    _____
17. Do you smoke? _____yes, ____no if quit, when _____

18. How many days a week do you eat/drink:
    _____Fish/seafood _____Processed Sugar (cookies, ice cream, etc.)
    _____Beans/Lentils _____Nuts/Seeds
    _____Berries _____All other fruit
    _____Cruciferous Vegetables (broccoli, cauliflower, brussels sprouts)
    _____Dark Leaky Green Vegetables (spinach, kale, arugula)
    _____Fast Food _____Processed meat (bacon, sausage etc.)
    _____Gum chewing
19. What do you typically eat for breakfast:
    _____
    _____
20. What do you typically eat for lunch:
    _____
    _____
21. What do you typically eat for dinner?
    _____
    _____
22. What do you typically snack on?
    _____
    _____
23. From the list below what triggers you to eat: availability of food _____loneliness _____habit _____ lack of appetite awareness ____external cues _____stress _____social situations _____sadness _____ anger _____depression _____boredom _____hunger _____self-reward _____comfort _____PMS _____anxiety other _____
24. Are you currently following a special diet (e.g., low fat, low salt)? Yes,_____ No_____
    If yes, what diet are you on? _____

25. On a scale of 1-10, how likely are you to make dietary changes? _____
26. On a scale of 1-10, with 10 being highly stressed, how would you rate your average daily stress level? _____
27. Where does stress originate (work, school, family etc.)_____
28. How many hours of sleep do you get a night? _____
29. Do you sleep well? Yes _____ No_____
30. On a scale of 1-5 please indicate your readiness/willingness to do the following

| Modify your diet | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|
| Keep record of your food and drink intake | | | | | |
| Modify your lifestyle: (ex: work demands sleep habits, physical activity) | | | | | |
| Engage in regular exercise/physical activity | | | | | |

31. What helps you stay motivated:

Accountability partner_____Weekly check in with people_____ Motivational books to read_____
Motivational sayings_____Having a community of other individuals doing the same thing to meet with

What are your top 2-3 health goals

_____
_____
_____
____