Health and Lifestyle Questionnaire

Name:____

Age: ____________ Height: ______________________ Weight: ______________________

Emergency contact:____---_________________
Relationship____________________________________Tel:_________________________________

What do you most hope to gain from Shape UP Boot Camp?

Top 3 goals in order of priority.
1____
2.____
3.____

Have you ever suffered from any of the following medical conditions?

Heart Disease;	**Yes**	**No**
Heart murmur	( )	( )
High Blood pressure	( )	( )
Angina	( )	( )
Heart Attack	( )	( )

Respiratory Disease:	**Yes**	**No**
Asthma	( )	( )
Bronchitis	( )	( )
Emphysema	( )	( )

Other	**Yes**	**No**
Stroke	( )	( )
Epilepsy	( )	( )
Arthritis	( )	( )
Cancer	( )	( )
Bone / Join Problems	( )	( )
Back Problem	( )	( )
Are You Pregnant	( )	( )
Medication	( )	( ) ______________________________

	Yes	**No**
Diabetes	( )	( )
Osteoporosis	( )	( )
Fibromyalgia	( )	( )
Fainting / Dizziness	( )	( )
Muscle Damage	( )	( )
Surgery	( )	( )

If you have answered yes to any of the above questions please give more information here_____________
____
____

Have you ever been advised not to exercise for any reason Yes / No. If yes, please give more details___
____
____

NOTE: If you answered yes to any of the above questions you will probably need to get **written consent** from your physician before commencing starting SHAPE UP BOOT CAMP
Date of Last Physical Examination: _______________________________
Family Physician: ______________________________Office #: ________________________
Specialist: ___________________________________ Office #:________________________
Physiotherapist:_______________________________ Office #:________________________

Life Assessment

Nutritional Profile:

Do you regularly eat: Breakfast ( ) Lunch ( ) Supper ( ) Snacks ( )
Do you regularly eat from the four food groups?

- Milk and Milk Products ( )
- Fruits and vegetables ( )
- Breads and Cereals ( )
- Meat and Poultry ( )

Is nutrition an area you feel you need more help? Yes / No

Do you diet? ___________. If yes, which diet? ______________. Average daily caloric intake _________
How often and how long do you diet? ____
Was it prescribed by a Physician? ____
Are you, or have you ever, taken any supplements? If so, what are you taking and how much? _________
____

Physical Fitness Profile:

When exercising (climbing stairs, walking briskly, shoveling snow etc) do you ever experience any of the following symptoms:

	Yes	No	Please explain
Shortness of Breath, coughing	( )	( )	________________
Headaches, nausea, dizziness	( )	( )	________________
Muscle or Joint discomfort	( )	( )	________________
Pain in Chest, shoulder, neck	( )	( )	________________
Pain in Legs or arms	( )	( )	________________

Are you currently participating in any other form of exercise? Yes / No
If yes, please give more information, what, how often, level of intensity. ___________________________
____

If no, how long since you last did, and what did you do?________________________________
____

Additional Profile:

Occupation: ____
Do you smoke? ___________. If yes, how long _____________and how many per day? _______________
How much alcohol do you drink per week? 0 – 10 units_________10 – 25 units________More than _____
How would you rank the stress in your life?
Mild ( ) Moderate ( ) High ( ) Very High ( )

Other Relevant Information:
____
____
____

Signature: ______________________________ Date: ______________________

Signature from Boot Camp Instructor / Assessor.______________________________