Health Assessment Questionnaire

Date: ____________

First Name: ____________ Last Name: ____________ Sex: ☐ M ☐ F

Age: ______ Email: ____________ Phone No: ____________

Your current weight: ____________ LB Height: ________ FT ________ IN

Desired body weight: ____________ LB

What is (are) your purpose (s) for participation in the 6-weeks Fitness Challenge?

☐ To lose weight ☐ Transformation (tone up) ☐ Other (please explain)

____

____

What do you feel are your challenges in achieving your fitness goals?

____

____

____

Current Diet

☐ Carnivore *(meat eater)* ☐ Pescatarian *(no meat but eat fish)* ☐ Vegetarian ☐ Vegan

Do you smoke?

☐ Never ☐ In the past ☐ Current – Packs per day

Do you drink alcoholic beverages?

☐ Yes ☐ No

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MEDICAL HISTORY

Allergies: ☐ Yes (please list) ____________________ No ☐

Please answer the following questions. Please check all that apply:

- ☐ Has a doctor ever said your blood pressure was too high?
- ☐ Do you ever have pain in your chest?
- ☐ Does your heart often race for unexplained reason?
- ☐ Do you suffer from frequent cramps in your legs?
- ☐ Do you often have difficulty breathing with minimal exertion?
- ☐ Do you sometimes get out of breath when sitting still or sleeping?
- ☐ Has a doctor ever told you your cholesterol level was high?
- ☐ Has a doctor ever told you that you have an abdominal aortic aneurysm?
- ☐ Has a doctor ever told you that you have critical aortic stenosis?

Have you been diagnosed with:

- ☐ Heart disease
- ☐ Hypertension
- ☐ Diabetes
- ☐ Dizziness or fainting spells
- ☐ Anemia
- ☐ Chronic back pain
- ☐ Chronic knee pain
- ☐ Asthma
- ☐ Epilepsy or seizures
- ☐ Hypoglycemia
- ☐ Other lung disease
- ☐ Injuries to arms, legs or join

List any prescription and over-the-counter medications you are taking CURRENTLY: