Happy Healthy Sexy Co.

Health History Questionnaire

Name: ______________________________

Date: ______________________________

Date of Birth: ______________________________

Address: ______________________________

Phone: ______________________________

Email: ______________________________

Emergency Contact / Phone: ______________________________

Present/Past History

Have you had, or currently have, any of the following? (Check all that apply)

- ☐ Cancer
- ☐ Diabetes
- ☐ Prediabetes
- ☐ Heart attack
- ☐ Chest pains
- ☐ Lung disease
- ☐ Kidney disease
- ☐ Unusual fatigue
- ☐ Low blood pressure
- ☐ High blood pressure
- ☐ Fainting or dizziness
- ☐ Seizures
- ☐ Rheumatic fever
- ☐ High cholesterol
- ☐ Recent operation
- ☐ Known heart murmur
- ☐ Muscle or joint problems
- ☐ Edema (swelling of ankles)
- ☐ Temporary loss of clear vision
- ☐ Any kind of heart disease or surgery
- ☐ Shortness of breath while lying down
- ☐ Intermittent claudication (calf cramping)
- ☐ Palpitations/tachycardia (strong/rapid heartbeat)
- ☐ Pain, discomfort in chest, neck, jaw, arms, or other areas
- ☐ Unusual fatigue or shortness of breath at rest or with light activity
- ☐ Other: ______________________________

Family History

Have any of your first degree relatives (parent, sibling, or child) experienced the following conditions? (Check all that apply.) Additionally, please identify at what age the condition developed/occurred.

- ☐ Diabetes
- ☐ Heart attack
- ☐ Heart surgery
- ☐ High cholesterol
- ☐ Other major illness: ______________________________
- ☐ Low blood pressure
- ☐ High blood pressure
- ☐ Congenital heart disease

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New Client Consultation

Name: ______________________ Date: ______________

What do you want to accomplish in the next 3-6 months?

What is your biggest struggle in reaching those goals?

Are you currently taking action towards your health & fitness goals? If so, what does that look like for you?

On a scale of 1-5 (5 being really confident), how would you rate your confidence level in the gym? Elaborate if you want!

On a scale of 1-5 (5 being highly motivated), how motivated are you to reach your goals?

Have you ever worked with a trainer before? If so, what did you like/dislike about your training program?

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New Client Consultation

Name: ______________________________ Date: __________________

Occupation:

How do you spend the majority of time at work? (Standing, sitting, active, etc)

What does your typical day look like?

How would you rate your current eating habits? (Poor, average, excellent)

How many meals do you eat each day?

Are you currently on a diet?

Do you take any vitamins or supplements?

How much water do you drink each day?

SMART Goal Setting

Specific	WHAT DO YOU WANT TO ACCOMPLISH?	S
Measurable	HOW WILL YOU KNOW WHEN YOU REACH YOUR GOAL?	M
Achievable	IS THIS SOMETHING YOU HAVE CONTROL OVER?	A
Relevant	WHY IS THIS APPLICABLE TO YOUR LIFE?	R
Time-Bound	WHEN DO YOU WANT TO ACHIEVE YOUR GOAL?	T