

# State of the Heart Fitness Client Information Health Questionnaire

***Please complete and return to State of the Heart Fitness as soon as you can.  
Once we receive it, we will call you to schedule your fitness assessment.***

All information received on this form will be treated as strictly confidential. Please complete and fill it out as accurately as possible. This information is essential to helping us develop a program that addresses your specific health needs and goals, but is also safe and effective and will provide the results you are looking for. We look forward to working with you!

Name:	_____	Date of Birth	___/___/___	Age:	_____
			M D Y		
Address:	_____				
	Street	City	State	Zip Code	
Phone:	_____ (h)	_____ (o)	_____ (fax)		
Email address:	_____ Would you like to be updated about our upcoming programs, activities, and discounts via our e-newsletter? ___Y ___N				
Occupation:	_____				
Emergency Contact:	_____	Relationship:	_____		
Phone Number:	_____				
Physician's Name:	_____	Physician's Phone:	_____		
Physician's Address:	_____				
	Street	City	State	Zip Code	

State of the Heart Fitness will send information regarding your physical exercise program to your physician unless you request otherwise.

**Please provide 24 hours notice if you need to cancel or reschedule your appointment.  
Any cancellations within a 24 hour period are subject to a cancellation fee.  
Thank you for understanding.**

## State of the Heart Fitness

Located at the Loews Santa Monica Beach Hotel  
1700 Ocean Ave Santa Monica, CA 90401  
Office. 310.899.4046 Voicemail: 310.842.5657 fax. 310.458.1286  
mailing address: P.O. Box 7013 Santa Monica, CA 90406  
info@stateoftheheartfitness.com [www.stateoftheheartfitness.com](http://www.stateoftheheartfitness.com)

# PAR-Q FORM

Please mark YES or No to the following:

YES NO

- Has your doctor ever said that you have a heart condition and recommended only medically supervised physical activity? \_\_\_\_\_
- Do you frequently have pains in your chest when you perform physical activity? \_\_\_\_\_
- Have you had chest pain when you were not doing physical activity? \_\_\_\_\_
- Do you lose your balance due to dizziness or do you ever lose consciousness? \_\_\_\_\_
- Do you have a bone, joint or any other health problem that causes you pain or limitations that must be addressed when developing an exercise program (i.e. diabetes, osteoporosis, high blood pressure, high cholesterol, arthritis, anorexia, bulimia, anemia, epilepsy, respiratory ailments, back problems, etc.)? \_\_\_\_\_
- Are you pregnant now or have given birth within the last 6 months? \_\_\_\_\_
- Have you had a recent surgery? \_\_\_\_\_

Do you take any medications, either prescription or non-prescription, on a regular basis? Yes/No

Please check which of the following conditions you have had or now have and list any medication you are currently taking for that condition. Also check medical conditions in your family (father, mother, brother(s), or sister(s)). Check all that apply.

Personal	Family	Medical Condition	Medication
<input type="checkbox"/>	<input type="checkbox"/>	Coronary heart disease, heart attack	_____
<input type="checkbox"/>	<input type="checkbox"/>	Angina	_____
<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure ____ mm Hg	_____
<input type="checkbox"/>	<input type="checkbox"/>	High cholesterol _____ mg/dl	_____
<input type="checkbox"/>	<input type="checkbox"/>	Peripheral vascular disease	_____
<input type="checkbox"/>	<input type="checkbox"/>	Phlebitis or emboli	_____
<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	_____
<input type="checkbox"/>	<input type="checkbox"/>	Stroke	_____
<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	_____
<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia	_____
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	_____
<input type="checkbox"/>	<input type="checkbox"/>	Bronchitis	_____
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes (specify type: _____)	_____
<input type="checkbox"/>	<input type="checkbox"/>	Thyroid conditions	_____
<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	_____
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	_____
<input type="checkbox"/>	<input type="checkbox"/>	Anemia (low iron)	_____
<input type="checkbox"/>	<input type="checkbox"/>	Bone fracture	_____
<input type="checkbox"/>	<input type="checkbox"/>	Depression	_____
<input type="checkbox"/>	<input type="checkbox"/>	High anxiety, phobias	_____
<input type="checkbox"/>	<input type="checkbox"/>	Eating disorders (anorexia, bulimia)	_____
<input type="checkbox"/>	<input type="checkbox"/>	Sleeping problems	_____

How does this medication affect your ability to exercise or achieve your fitness goals?

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If you have marked YES to any of the above, please elaborate below:

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### Health & Fitness Goals:

**How can we help you? Please check that which applies.**

- Lose Body Fat    Develop Muscle Tone    Rehabilitate an Injury    Nutrition Education    Start an Exercise Program    Design a more advanced program    Safety  
 Sports Specific Training    Increase Muscle Size    Fun    Motivation  
Other \_\_\_\_\_

1. Please list in order of priority, the fitness goals you would like to achieve in the next 3-12 months?

- a) \_\_\_\_\_  
b) \_\_\_\_\_  
c) \_\_\_\_\_

2. Where do you rate health in your life?    Low priority    Medium Priority    High priority

3. How committed are you to achieving your fitness goals?    Very    Semi    Not very

4. What do you think the most important thing we can do to help you achieve your fitness goals?

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5. Outline what you feel are the obstacles or your potential actions, behaviors or activities that could impede your progress towards accomplishing your goals (i.e. not training consistently, upcoming vacation, busy season at work, not following the program, allowing other responsibilities to become a priority over exercise etc.).

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6. Outline 3 methods that you plan to use to overcome these obstacles:

- a. \_\_\_\_\_ b. \_\_\_\_\_ c. \_\_\_\_\_

### Fitness History:

1) When were you in the best shape of your life? \_\_\_\_\_

2) Have you been exercising consistently for the past 3 months? YES NO

3) When did you first start thinking about getting in shape? \_\_\_\_\_

4) What if anything stopped you in the past? \_\_\_\_\_

5) On a scale of 1-10, how would you rate your present fitness level (1=Worst 10=Best)? \_\_\_\_\_

**Lifestyle Related Questions:**

- 1) Do you smoke?                    YES    NO    If yes, how many? \_\_\_\_\_
  - 2) Do you drink alcohol?            YES    NO    If yes, how many glasses per week? \_\_\_\_\_
  - 3) How many hours do you regularly sleep at night?    \_\_\_\_\_
  - 4) Describe your job:     Sedentary     Active     Physically Demanding
  - 5) Does your job require travel? YES    NO
  - 6) On a scale of 1-10, how would you rate your stress level (1=very low 10=very high)? \_\_\_\_\_
  - 7) List your 3 biggest sources of stress:  
a. \_\_\_\_\_ b. \_\_\_\_\_ c. \_\_\_\_\_
  - 8) Is anyone in your family overweight?     Mother     Father     Sibling     Grandparent
  - 9) Were you overweight as a child?    YES    NO    If yes, at what age(s)? \_\_\_\_\_
  - 10.) How do you see yourself and your life in 5 years? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- 
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**Nutrition Related Questions:**

- 1) On a scale of 1-10, how would you rate your Nutrition (1=very poor 10=excellent)? \_\_\_\_\_
- 2) How many times a day do you usually eat (including snacks)? \_\_\_\_\_
- 3) Do you skip meals? YES    NO            4) Do you eat breakfast? YES    NO
- 5) Do you eat late at night?     Sometimes     Often     Never
- 6) What activities do you engage in while eating? (TV, reading etc) \_\_\_\_\_
- 7) How many glasses of water do you consume daily? \_\_\_\_\_
- 8) Do you feel drops in your energy levels throughout the day? YES NO If yes, when? \_\_\_\_\_
- 9) Do you know how many calories you eat per day? YES NO If yes, how many? \_\_\_\_\_
- 10) Are you currently or have you ever taken a multivitamin or any other food supplements? Y N  
If yes, please list the supplements:  
\_\_\_\_\_  
\_\_\_\_\_
- 11) At work or school, do you usually:     Eat out     Bring food
- 12) How many times per week do you eat out? \_\_\_\_\_
- 13) Do you do your own grocery shopping? YES    NO
- 14) Do you do your own cooking?            YES            NO

15) Besides hunger, what other reason(s) do you eat?

- Boredom    Social    Stressed    Tired    Depressed    Happy    Nervous

16) Do you eat past the point of fullness?  Often    Sometimes    Never

17) Do you eat foods high in fat and sugar?  Often    Sometimes    Never

18) List 3 areas of your Nutrition you would like to improve:

a. \_\_\_\_\_ b. \_\_\_\_\_ c. \_\_\_\_\_

**Exercise Related Questions:** Skip to the next section if you are presently inactive.

1) How often do you take part in physical exercise?

- 5-7x/week   3-4x/week   1-2x/week

2) If your participation is lower than you would like it to be, what are the reasons?

Lack of Interest   Illness/Injury   Lack of Time   Other \_\_\_\_\_

3) How long have you been consistently physically active for? \_\_\_\_\_

4) What activities are you presently involved in?

Cardio &/or Sports	Frequency/Week	Average Length	Easy/Mod/Hard
_____	_____	_____	_____
_____	_____	_____	_____

Strength Training	Frequency/Week	Average Length	Easy/Mod/Hard
_____	_____	_____	_____

Stretching	Frequency/Week	Average Length
_____	_____	_____

5) Please circle all the activities that interest you:

- |                         |                           |                     |
|-------------------------|---------------------------|---------------------|
| Aerobic Fitness Classes | Indoor Cycling            | Snowshoeing         |
| Baseball                | Kayaking                  | Soccer              |
| Basketball              | Partner Training          | Swimming            |
| Boxing                  | Pilates                   | Tennis              |
| Cross Country Skiing    | Private Personal Training | Triathlon           |
| Football                | Racquetball               | Volleyball          |
| Golf                    | Rockclimbing              | Walking             |
| Group Personal Training | Running                   | Wallyball           |
| Hiking                  | Skiing                    | White Water Rafting |
| Ice Skating             | Snowboarding              | Yoga                |

**Developing your Fitness Program:**

1. Please circle how you prefer to exercise:

- a)    INSIDE            OUTSIDE            COMBINATION
- b)    LARGE GROUPS    SMALL GROUPS    ALONE            COMBINATION
- c)    MORNING    AFTERNOON    EVENING

2. Realistically, how often a week would you like to exercise? \_\_\_\_\_x/week

3. Realistically, how much time would you like to spend during each exercise session? \_\_\_\_\_

4. What are the best days during the week for you to commit to your exercise program?

M T W T F S S

5. If you could design your own exercise program, what would an ideal training week look like to you? Please be specific. List your favorite activities, rest days, time spent etc.

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY

**Miscellaneous Questions:**

1. How did you hear about us? Please check that which applies.

- Brochure  Word of Mouth  Flyer  Newsletter  Website
- Loews Santa Monica Beach Hotel  Health Professional (Doctor, Dietitian, Physical Therapist, etc)  Meal Delivery Program  WRS  Other \_\_\_\_\_

2. If you were referred to us, who told you about our services?

3. Why did you choose to work with State of the Heart Fitness instead of another organization? Please check that which applies.

- Location  Personal Trainers  Cost  Customer Service  Word of Mouth  Programs
- Other \_\_\_\_\_

4. How far do you live from our facility? \_\_\_\_\_ miles

5. **THE GIFT OF HEALTH & FITNESS:** Do you know of anyone who could use some assistance with their health & fitness needs and would benefit from a complimentary consultation? Y or N

If yes, please provide their name & phone number and we will offer this service to them as a gift from YOU!

***You just might be the one directly responsible for adding years to their life and life to their years!***

1. Name \_\_\_\_\_ Phone Number  
( ) \_\_\_\_\_

2. \_\_\_\_\_ ( ) \_\_\_\_\_