



# Venus Fitness & Lifestyle Coaching

## Health History & Lifestyle Information

NAME: _____	AGE: _____
EMAIL ADDRESS: _____	PHONE #: _____
PHYSICIANS NAME: _____	PHONE #: _____
EMERGENCY CONTACT: _____	PHONE #: _____

### **HEALTH HISTORY** Do you know, or have you had in the past: Please circle one

- |  |   |   |
|--|---|---|
| 1. History of heart problems, chest pain or stroke                             | Y | N |
| 2. Increased blood pressure (normal BP _____)                                  | Y | N |
| 3. Any chronic illness or condition  | Y | N |
| 4. Difficulty exercising   | Y | N |
| 5. Advice from physician not to exercise                                       | Y | N |
| 6. Recent surgery (last 12 months)   | Y | N |
| 7. Pregnancy (now or within last 3 months)                                     | Y | N |
| 8. History of breathing or lung problems                                       | Y | N |
| 9. Muscle, joint, or back disorder, or any previous injury still affecting you | Y | N |
| 10. Diabetes or thyroid  | Y | N |
| 11. Increased blood cholesterol  | Y | N |
| 14. History of heart problems in immediate family                              | Y | N |
| Normal resting heart rate _____  |   |   |
| 15. Hernia, or any condition that may be aggravated by lifting weights         | Y | N |
| 16. Any allergies  | Y | N |

Please explain any "Yes" answers: \_\_\_\_\_

Check off if you are seeing a Health Care Specialist:

- Physiotherapist     
  Chiropractor     
  Natural path     
  Medical Specialist

Other \_\_\_\_\_

Comments \_\_\_\_\_

Do you take any medications (either prescription or non-prescription on a regular basis)?

- No     Yes     
 What is the medication for? \_\_\_\_\_

How does it affect your ability to exercise? \_\_\_\_\_

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Consultant Signature

### **LIFESTYLE INFORMATION**



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Please circle one

1. Do you consistently and regularly eat four to five "meals" a day? Y N
2. Do you drink 8 glasses of water each day? Y N
3. Do you eat at least 4 servings of bread, cereal, rice, or pasta a day? Y N
4. Do you eat at least 2 servings of fruit per day? Y N
5. Do you eat at least 3 servings of vegetables per day? Y N
6. Do you have at least 2 servings of quality protein per day? Y N
7. Do you eat foods high in saturated fat, high in refined sugar and/or high in salt content more than 2-3 times a week? Y N
8. Do you take vitamins or supplements? Y N
9. How many cups of coffee do you have per day  0  1-2  3-5  >6
10. How many glasses of alcohol do you drink a week?  0  1-2  3-5  >6
11. Do you smoke? Y N
12. How many hours do you regularly sleep a night? \_\_\_\_\_
13. My low energy time of the day is \_\_\_\_\_ My high energy time is \_\_\_\_\_
14. What motivates you to get and be fit? \_\_\_\_\_

15. On a scale of 1 to 10, how would you rate your present fitness level (10 = best)? \_\_\_\_\_

16. Are you satisfied with your current level of fitness? Y N

17. How often do you currently participate in physical activity?  
 5-7 times/week  3-4 times/weeks'  1-2 times/week  not in 6 months

18. If active, list your activities

<i>Activity</i>	<i>Frequency/Week</i>	<i>Average Time</i>	<i>Easy/Mod/Hard</i>

19. What fitness activities interest you?  
 weight training  cycling  yoga  pilates  ball  
 group training  outdoor urban workouts

20. Rate 1-5 for each of the following goals (1 = not as important; 5 = important)  
 \_\_\_ Reduce Body Fat      \_\_\_ Reshape body      \_\_\_ Increase energy levels  
 \_\_\_ Cardiovascular Fitness      \_\_\_ Muscle Strength      \_\_\_ Improve flexibility  
 \_\_\_ Reduce stress      \_\_\_ Performance Specific Training  
 \_\_\_ Reduce health risks

21. What challenges do face in achieving your ideal physical state?  
 Negative exercise experience  Boredom  Work hours  
 Family commitments  Lifestyle habits  Changing energy levels  
 Time management  Nutrition  Discipline  
 Lack of consistency  Smoking  No exercise partner  
 Lack of motivation

## MY EXERCISE PLAN



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1. What would you like to accomplish during the next:

1 month: \_\_\_\_\_

6 months: \_\_\_\_\_

1 year: \_\_\_\_\_

*I can commit to:*

**#Days a Week:**

1      2      3      4      5      6

**Time Per workout**

1hr      1.25hrs      1.5hrs      2hrs

**Personal Trainer to complete**

2. Cardio Workout: \_\_\_\_\_/week      Type \_\_\_\_\_

Strength: \_\_\_\_\_/week      Type \_\_\_\_\_

Stretching: \_\_\_\_\_/week      Type \_\_\_\_\_

3.

<i>DAY</i>	<i>TYPE OF EXERCISE</i>	<i>TIME OF EACH</i>
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		
Saturday		
Sunday		

4. Obstacles to my exercise plan:

\_\_\_\_\_

\_\_\_\_\_

5. Strategies to stay on track:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_