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WEIGHT LOSS AND FITNESS PRE-ASSESSMENT QUESTIONNAIRE

This questionnaire is designed to gather essential medical, lifestyle, and fitness information to create a safe and effective program tailored to your needs.

Personal Information

1. Full Name: _____
2. Date of Birth: _____
3. Contact Information: _____
4. Emergency Contact: _____

Medical History

5. Do you have any known medical conditions?
   - ☐ Hypertension ☐ Diabetes ☐ Heart disease
     ☐ Asthma or respiratory issues ☐ Joint or musculoskeletal problems
   - ☐ Other (Please specify: _____)

6. Are you currently taking any medications?
   - ☐ Yes (Please list: _____) ☐ No

7. Have you ever been hospitalized or undergone surgery?
   - ☐ Yes (Please specify: _____) ☐ No

8. Do you have any allergies (e.g., food, medications, etc.)?
   - ☐ Yes (Please list: _____) ☐ No

9. Have you experienced any of the following? (Check all that apply)
   - ☐ Chest pain during physical activity
   - ☐ Shortness of breath
   - ☐ Dizziness or fainting
   - ☐ Chronic fatigue
   - ☐ Other (Please specify: _____)

10. Have you had a recent physical examination or blood work?
    - ☐ Yes (Please share results if available)
    - ☐ No

Lifestyle and Habits

11. What is your current weight? _____ kg/lbs
12. What is your height? _____ cm/ft
13. What is your goal weight? _____ kg/lbs

14. How would you describe your current activity level?
    - ☐ Sedentary (little to no exercise)
    - ☐ Lightly active (light exercise 1-3 days/week)
    - ☐ Moderately active (moderate exercise 3-5 days/week)
    - ☐ Very active (intense exercise 6-7 days/week)

15. Do you currently exercise?
    - ☐ Yes (Please describe: _____)
    - ☐ No

16. What is your typical daily diet like?
    - ☐ Balanced (fruits, vegetables, lean proteins, etc.)
    - ☐ High in processed foods
    - ☐ High in carbohydrates
    - ☐ Other (Please describe: _____)

17. How many meals do you eat per day?
    - ☐ 1-2
    - ☐ 3
    - ☐ 4 or more

18. Do you consume alcohol?
    - ☐ Yes (How often? _____)
    - ☐ No

19. Do you smoke or use tobacco products?
- ☐ Yes - ☐ No

20. How many hours of sleep do you get per night?
- ☐ Less than 5 hours
- ☐ 5-7 hours
- ☐ 7-9 hours
- ☐ More than 9 hours

21. Do you experience high levels of stress?
- ☐ Yes - ☐ No

Fitness Goals

22. What are your primary fitness goals? (Check all that apply)
- ☐ Weight loss
- ☐ Improved cardiovascular health
- ☐ Increased muscle strength
- ☐ Better flexibility and mobility
- ☐ Stress reduction
- ☐ Other (Please specify: _____)

23. Do you have any specific preferences for exercise?
- ☐ Gym workouts
- ☐ Outdoor activities (e.g., running, cycling)
- ☐ Group classes (e.g., yoga, Pilates)
- ☐ Home workouts
- ☐ Other (Please specify: _____)

24. Are there any exercises or activities you avoid due to discomfort or injury?
- ☐ Yes (Please specify: _____)
- ☐ No

Motivation and Challenges

25. What motivates you to lose weight and improve your fitness?
    - ☐ Health concerns
    - ☐ Improved appearance
    - ☐ Increased energy levels
    - ☐ Family or social reasons
    - ☐ Other (Please specify: _____)

26. What challenges do you anticipate in achieving your goals?
    - ☐ Lack of time
    - ☐ Lack of motivation
    - ☐ Physical limitations
    - ☐ Dietary habits
    - ☐ Other (Please specify: _____)

Consent and Acknowledgment

27. I understand that this program is designed to improve my health and fitness, and I agree to follow the recommendations provided by my healthcare provider.
    - ☐ Yes - ☐ No

28. I acknowledge that I have disclosed all relevant medical information and will inform my provider of any changes in my health status.
    - ☐ Yes
    - ☐ No

Signature: _____

Date: _____