So.Be.Fit. Consultation Questionnaire

Name: ______________________________

Date:
Phone Number:
E-Mail:
Emergency Contact:

Demographics

Sex: **Age:**

Height: **Weight:** **BMI (do not fill in):**

Current Medical/Physical Conditions

Past Medical/Physical Conditions:

Current Medications (please also list experienced side effects):

Family Health History:

Exercise History

Please describe all current weekly exercise:

Describe any obstacles (either lifestyle related, such as time, or mental beliefs) toward exercise:

Were you active as a child?

What are your preferred aerobic activities?

Have you participated in a resistance training program such as: free weights, bands, weight machines?

Exercise Rationale

What are your primary reasons for beginning/continuing an exercise program (in order of importance)?

Has your doctor recommended that you begin (or not begin) an exercise program? If so, please explain.

What time(s) do you prefer/are available to exercise?

What are your goals for beginning an exercise program?
In the next month:

In the next year:

Diet

Please list typical diet:

Describe biggest Diet Obstacles: