

Health and Lifestyle Questionnaire



PRIFYSGOL CYMRU
Y Drindod Dewi Sant
UNIVERSITY OF WALES
Trinity Saint David

NAME: _____

D.O.B. _____

ADDRESS _____

TEL (H): _____ (W): _____ E.MAIL: _____

Doctors Name: _____ Tel: _____

In case of emergency, whom may we contact?

Name: _____ Relationship: _____

Tel: (H): _____ (W): _____

CONFIDENTIAL HEALTH QUESTIONNAIRE

HAVE YOU OR DO YOU SUFFER FROM ANY OF THE FOLLOWING.

(Please tick & give details where applicable)

Asthma	Heart Attack	Rheumatic Fever
Angina	Diabetes	High Cholesterol
High Blood Pressure	Frequent Colds	Atrial Fibrillation
Low Blood Pressure	Dizziness/fainting	Headaches
Epilepsy	Heart Disease	Migraines
Arthritis	Shortness of breath	Heart Surgery

DETAILS: _____

Have any of your first-degree relatives experienced the following conditions?

Heart attack ☐ Heart operation ☐ Congenital heart disease ☐ High cholesterol ☐

Have you ever had surgery? Yes ☐ No ☐ If yes give details.

Have you ever broken any bones? Yes ☐ No ☐ If yes give details.

Do you suffer from back pain?

Yes ☐ No ☐ If yes give details.

Do you experience numbness, tingling or stabbing pains anywhere? Yes ☐ No ☐ If yes give details.

Do you experience stiff, swollen or painful joints? Yes ☐ No ☐ If yes give details.

Are you receiving therapy, physiotherapy or massage? Yes ☐ No ☐ If yes give details.

Do you experience fatigue or lack of energy? If yes provide details.

What is your current weight?

Please list any medications you are currently taking.

CONFIDENTIAL LIFESTYLE QUESTIONNAIRE

On a scale of 1 to 10 (1=not active, 10=very active) please rate how active you are on a daily basis?

How many hours sleep do you get everyday?

Do you consider yourself to be under stress? If yes provide details.

Circle the following in order of importance to you:

1 = Very Low 2 = Low 3 = Moderate 4 = High 5 = Very High

Fat Loss	1	2	3	4	5
Aerobic Fitness	1	2	3	4	5
Physique	1	2	3	4	5
Strength	1	2	3	4	5

Are you currently exercising? (if so provide details)

Number the type of training you prefer in a fitness facility (1 being the best)

Cycle	Treadmill	Rower	Cross Trainer	Swimming
-------	-----------	-------	---------------	----------

Do you smoke? Yes ☐ No ☐ If yes, how many per day _____

Average Daily Dietary Intake

No. of cups of coffee _____
No. of cups of tea _____
Pints of Lager/Beer _____
Glasses of Wine _____
Glasses of Spirits _____

Amount of Sugar _____
Chocolates _____
Sweets _____
Alcohol _____
Portions of Fruit _____

CONFIDENTIAL GOAL QUESTIONNAIRE

How much time are you willing to devote toward achieving this goal?

What is the biggest challenge you must overcome in attaining your goal?

On a scale of 1 to 10 (1=not committed, 10=very committed), please rate how committed you are to achieving your goal?

List three tasks you can do daily, which will help to achieve your aims?

1. _____

2. _____

3. _____

All information I have provided is correct to the best of my knowledge and I have sought, and followed, any necessary medical advice.

Client's Signature: _____ Date: _____

Supervisor's Signature _____ Date: _____