

RAW Center for Strength

1543 Palos Verdes Mall
Walnut Creek, CA 94597
925-930-0519

Health, Wellness and Lifestyle Questionnaire

Name: _____

Date: _____

Address: _____

Birthday: _____

Age: _____

Sex: M F

Home Phone: _____ **Occupation:** _____

Cell Phone: _____

Work Phone: _____ **Employer:** _____

Email Address: _____

Physician's Phone #: _____

Date of last Physical: _____

How did you hear about us? _____ (word of mouth, phone book, friend, RAW Newsletter, other)

If you are under 18, what are your parent's names:

Mom: _____

Dad: _____

The following information is required to assess your physical fitness level and to establish your exercise prescription. Your health questionnaire and test results are confidential and will not be released to anyone other than yourself.

Have you ever experienced any of the following while walking, working or exercising?

Pain in the chest Y N

Pain in the neck Y N

If so, what side: _____

Pain in the lower back Y N

If so, what side: _____

Shortness of breath Y N

Faintness/ Light headed Y N

Confusion/ Dizziness Y N

Leg Pain Y N

If so, what side: _____

Heart beat irregularities Y N

Persistent cough Y N

To your knowledge do you have or have you had any of the following?

Diabetes Y N

Heart/Cardiopulmonary disease Y N

-Heart murmur, angina, heart attack, coronary, arteriosclerosis

Pulmonary disease Y N

-Asthma, emphysema, bronchitis

Gout (elevated uric acid) Y N

Thyroid, Kidney or Liver disease Y N

Stroke Y N

Rheumatic fever Y N

Anemia-low red blood cell count Y N

Hernia Y N

Varicose Veins Y N

AIDS or HIV Positive Y N

Have you recently experienced any of the following:

Localized muscle soreness Y N

Joint Stiffness Y N

Flare-up of old injuries Y N

Loss of local muscle strength Y N

Noticeable loss of muscle size Y N

Restricted joint movement Y N

Has your personal physician indicated that you have:

High Blood Pressure Y N

-If yes, please indicate Systolic _____ Diastolic _____

Elevated Blood Cholesterol Y N

-If yes, please indicate level _____

Family history of either of the above? _____

Do you take any medication on a regular basis? If yes, please list

Prescription

Non-Prescription

Please note any surgeries or injuries (past or present)

Foot Left _____

Right _____

Ankle Left _____

Right _____

Knee Left _____

Right _____

Hip Left _____

Right _____

Shoulder Left _____

Right _____

Elbow` Left _____

Right _____

Wrist Left _____

Right _____

Hand Left _____

Right _____

Neck Left _____

Right _____

Back Left _____

Right _____

Do you smoke a pipe, cigars or cigarettes? Y N

Per day _____ # of years _____

If you have smoked, how long has it been since you quit?

Do you consume alcoholic beverages? Y N

If yes, Daily _____ Weekly _____ Monthly _____

How much: _____

Do you diet?

If yes, why? Weight loss _____ Weight Gain _____ Medical _____

Explanation _____

Do you feel your current diet is successful? Y N

What type of diet are you currently trying?

What types of diets have you tried in the past?

Were they successful or unsuccessful and why?

Do you currently or have you in the past suffered from an eating disorder?

If yes, please explain.

Please describe your current typical eating habits.

Time Food

Morning _____

Snack _____

Mid-Day _____

Snack _____

Evening _____

Estimated number of glasses of water consumed each day _____

Under what circumstances do you tend to overeat or eat foods you know that you shouldn't?

Please list your current participation in physical activities:

What activities Times Per Week Minutes/Session

What usually interrupts your work out program?

How long do you usually stick with a work out program?

If you stop working out for an extended period of time, why?

How many hours of sleep do you average per night? _____

Please rate your current life stress level: (1-10; 10 is the highest stress level)

Rating: _____

Please list your current fitness goals in each category that applies, 1 being the most important and a 5 being the least importance.

Health (lower cholesterol, blood pressure, body fat, etc)

Weight Loss/Gain

Appearance/Body Parts

Pain Management

Flexibility

Posture

Job Performance

Sports Performance

Special Occasion (wedding, anniversary, vacation, etc)

How much time can you devote to your work out program?

Days/Week _____ Minutes/Day _____

What types of exercise interests you?

Walking	Stationary Bike	Rollerblading
Jogging/Running	Rowing	Pilates
Swimming	Cycling	Yoga
Tennis	Aerobics	_____
Strength Training	Flexibility	_____
Cross Training	Par courses	_____
Stairmaster	Water Aerobics	_____

LIABILITY WAIVER

The undersigned recognizes that the use of Raw Center for Strength's services involve an inherent risk of physical injury including that caused by the negligence of the undersigned, Tom Pete, Raw Center for Strength, or contractors and employees of Raw Center for Strength. The undersigned hereby agrees to assume the risk of injury in its entirety regardless of the cause. Tom Pete, Raw Center for Strength, and all contractors and employees of Raw Center for Strength shall not be liable for injuries or damages to the undersigned, or the property of the undersigned, or by subject to any claim, demand, injury, death, or damages whatever, including, without limitation, those damages resulting from acts of active or passive negligence on the part of Tom Pete, Raw Center for Strength, and all contractors and employees of Raw Center for Strength for all such claims, demands, injuries, death, damages, actions, or causes of action. It is specifically agreed that Tom Pete, Raw Center for Strength, and all contractors and employees of Raw Center for Strength shall not be responsible or liable to the undersigned for articles lost or stolen in connection with Tom Pete, Raw Center for Strength, or contractors and employees of Raw Center for Strength's service.

Print Name: _____

Signature: _____

Date: _____

If under 18 years of age, please have parents sign here:

Print Name: _____

Parent's Signature: _____

Date: _____

Cancellation Policy: To give our staff advance notice we do require that you give us 24 hours notice for any appointments that need to be cancelled to insure that you will not be charged. Thank you!!