

Lifestyle Assessment

CLIENT NAME:

Date of Birth:

Height:

Weight:

WORK

What do you do for a living?

Do you mostly sit, stand, or walk around during your work hours?

HOME/FAMILY

Are you Single/Married/Divorced?

Do you have any Children?

Any Pets?

Please briefly describe your family, home, and social life:

STRESS

What would you rate your current stress level (low, medium, high, extremely high)?

What causes you to feel stressed?

SLEEP

How many hours do you typically sleep per night?

What time do you wake up?

What time do you go to bed?

NUTRITION

Do you drink coffee, take caffeine supplements, or any other stimulants?

If yes, please list what kind and how often, and what time(s) of day you take them:

Do you have any food allergies, sensitivities, and/or intolerances? Please explain:

What foods do you dislike or refuse to eat?

What are your favorite foods to eat?

Are you currently taking any ergogenic aids, over the counter supplements, vitamins/minerals, protein powders or meal replacements?

Are you an emotional eater (do you eat when you are: you are tired, stressed, sad, angry, depressed, happy)?

Have you ever suffered from any eating disorders or disordered eating such as Anorexia-Nervosa, Bulimia, Binge Eating with or without purging?

HOBBIES

Please list any leisure and fitness activities which you currently participate in or enjoy:

Please list hobbies/activities that help you relax:

Do you practice any relaxation techniques, meditation, breath-work, yoga, or mobility exercises?
If yes, please explain:

PHYSICAL ACTIVITY

How many steps per day do you average?

How many days per week can you (realistically) dedicate to working out?

How much time per day can you (realistically) dedicate to working out?

Do you need any at home workouts? If so, how many?

Do you have workout equipment at HOME?

If yes, please list ALL fitness equipment:

Do you have a gym membership?

If yes, which gym(s)?

WORKOUTS/CURRENT TRAINING PROGRAM

Please tell me about your current workout program and any fitness related activities and time dedicated.

List all workouts according to what your current program entails.

List weight training workouts (body parts trained, reps, sets, tempo, and rest periods if possible)

List any cardio activity (type of cardio/cardio machine, speed (mph) or rpms, incline, resistance, time, etc.)

Take as much space as needed.

Monday

Tuesday

Wednesday

Thursday

Friday

Saturday

Sunday

On a scale of 1-10 how would you rate your exertion level on average during your workouts?

What body parts or areas of your health and fitness do you want to change the most? And Why?

Describe how you FEEL about your CURRENT state of health and fitness and how you feel about yourself:

What barriers/obstacles have you faced in the past or are you currently struggling with reaching your goals?

What are some common excuses you have used for not exercising or for making unhealthy food choices?
-examples include: too tired, not enough time, headache, lazy, sore, the weather is bad, sick, etc.

What motivates you to become healthier?

How did you hear about me?

Why do you want to work with me?

What are your goals? What do you want to accomplish working with me?

Please see the Goals Worksheet for help in mapping out your goals.