PN Initial Assessment & Triage Questionnaire

NAME ..... DATE .....

Tell me more about yourself.

By learning more about your lifestyle and your habits, I can take better care of you and make sure coaching is a good fit for your goals and individual needs.

DATE OF BIRTH ..... GENDER .....

Staying in touch

Please print clearly.

EMAIL ..... MOBILE PHONE ..... HOME PHONE .....

How do you prefer me to contact you?

- ◯ Email
- ◯ Phone
- ◯ Skype or other video chat
- ◯ Text
- ◯ Other (please specify): .....

Emergency contact name: .....

Emergency contact phone number: .....

What do you want?

In general, what are your goals? Check all that apply.

- ◯ Lose weight / fat
- ◯ Gain weight
- ◯ Maintain weight
- ◯ Add muscle
- ◯ Improve physical fitness
- ◯ Look better
- ◯ Feel better
- ◯ Have more energy and vitality
- ◯ Get control of eating habits
- ◯ Get stronger
- ◯ Physique competition / modeling
- ◯ Improve athletic performance

Please list all of your concerns about your health, eating habits, fitness, and / or body.

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Out of all of the above concerns, which ones feel most important / urgent?

1.
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2.
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3.
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Why?

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What do you expect?

What do you expect from me as your coach?

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What are you prepared to do to work towards your goals?

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What do you want to change?

Have you tried anything in the past to change your habits, your health, your eating, and / or your body? Y N
If so, what?

Which of those things worked well for you? (Even if you might not be doing it right now.)

Which of those things didn't work well for you?

How, specifically, would you like your habits, your health, your eating, and / or your body to be different?

Have you already made changes to your habits, your health, your eating, and / or your body recently? Y N
If so, what?

If you were to consider making further changes to your habits, your health, your eating, and / or your body, what might those be?

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Until now, what has blocked you or held you back from changing these things?

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Right now, how would you rank your overall eating / nutrition habits?

HORRIBLE (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) AWESOME!!!

Why?

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Are you regularly active in sports and / or exercise? (Y) (N)

If so, approximately how many hours per week?

- ◯ Fewer than 5 hours
- ◯ 5-9
- ◯ 10-14
- ◯ 15-19
- ◯ 20 or more

What types of sports and / or exercise do you typically do?

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Approximately how many hours a week do you do other types of physical activity? (e.g., housework, walking to work or school, home repairs, moving around at work, gardening)

- ◯ Fewer than 5 hours
- ◯ 5-9
- ◯ 10-14
- ◯ 15-19
- ◯ 20 or more

What other types of movement and / or activities do you do?

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What's around you?

Who lives with you? Check all that apply.

- ◯ Spouse or partner(s)
- ◯ Roommate(s)
- ◯ Child(ren)
- ◯ Pet(s)
- ◯ Other family (e.g. parent, grandparent, sibling, etc.)

Do you have children? If yes, how many and what are their ages? (Y) (N)

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Who does most of the grocery shopping in your household? Check all that apply.

- ◯ Me
- ◯ Spouse or partner(s)
- ◯ Roommate(s)
- ◯ Child(ren)
- ◯ Other family

Who does most of the cooking in your household? Check all that apply.

- ◯ Me
- ◯ Spouse or partner(s)
- ◯ Roommate(s)
- ◯ Child(ren)
- ◯ Other family

Who decides on most of the menus / meal types in your household? Check all that apply.

- ◯ Me
- ◯ Spouse or partner(s)
- ◯ Roommate(s)
- ◯ Child(ren)
- ◯ Other family

Right now, how much do the people and things around you support health, fitness, and / or behavior change?

NOT AT ALL (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) COMPLETELY

What's your health like?

Have you have been diagnosed (currently or in the past) with any significant medical condition(s) and / or injuries? Y N

Right now, do you have any specific health concerns, such as illnesses, pain, and / or injuries? Y N

Right now, are you taking any medications, either over-the-counter or prescription? Y N

On a scale of 1-10, how would you rank your health right now?

WORST 1 2 3 4 5 6 7 8 9 10 AWESOME!!!

Why?

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How are you spending your time?

In an average week, how many hours do you spend...

..... In paid employment?

..... At school or doing school work?

..... Traveling and / or commuting?

..... Taking care of others? (e.g., children, person with a disability, older person)

..... Doing other unpaid work? (e.g., housework, errands)

..... Volunteering?

Adding up all these things, how many total hours per week do you spend doing all these activities? .....

On a scale of 1-10, how do you feel about your schedule, time use, and overall busy-ness?

MY LIFE IS PANICKED AND INSANE 1 2 3 4 5 6 7 8 9 10 MY LIFE IS PERFECTLY CALM AND RELAXED

How is your stress and recovery?

Think about all the activities you're involved in (e.g., work, school, caregiving, housework, travel). Then assess as best you can:

Given all the demands of your life, what is your typical stress level on an average day?

NO STRESS (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) EXTREME STERSS

On average, how many hours per night do you sleep?

- ○ 4 or fewer hours
- ○ 5 hours
- ○ 6 hours
- ○ 7 hours
- ○ 8 hours
- ○ 9 hours
- ○ 10 or more hours

How do you normally cope with your stress?

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How ready, willing, and able are you to change?

Right now, on a scale of 1-10:

How READY are you to change your behaviors and habits?

NOT AT ALL (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) COMPLETELY

How WILLING are you to change your behaviors and habits?

NOT AT ALL (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) COMPLETELY

How ABLE are you to change your behaviors and habits?

NOT AT ALL (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) COMPLETELY

Disclaimer

Please recognize that it is your responsibility to work directly with your health care provider before, during, and after seeking nutrition and / or fitness consultation.

Any information provided is not to be followed without prior approval of your doctor. If you choose to use this information without such approval, you agree to accept full responsibility for your decision.

Client signature:

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