

Wellness Readiness Questionnaire

Name: _____
DOB: _____ Age: _____
Occupation: _____

1. Please check if you have or had. List medications or dates for each:

- High Blood Pressure _____
- Heart Problems _____
- Pacemaker, Heart Catheterization, Angioplasty _____
- Atherosclerosis _____
- Muscle, Joint, or Back Disorders _____
- Arthritis or Joint Problems _____
- High Cholesterol _____
- Diabetes _____
- History of Seizures, Epilepsy _____
- Stroke (CVA) _____
- Blood Clots _____
- Dizziness/Fainting _____
- Asthma, COPD, Emphysema, or Lung Problems _____
- Family History of Heart Disease _____
- Allergies _____
- Chronic Illness _____
- Thyroid Disorders _____
- Cancer (list type) _____
- Kidney Disease _____
- Neurological Disorder _____
- Osteoporosis _____
- Pregnant _____
- Hernia _____
- Tobacco Use _____
- Alcohol Consumption (amount/type) _____
- Caffeine Consumption (amount) _____
- Difficulty with Physical Exertion _____
- Eating Disorder _____
- Depression _____
- Headaches, Fatigue, Weight Changes _____
- Orthopedic Surgeries _____
- General Surgeries _____
- Other Health Issues _____
- Other Medications Not Listed _____

2. How would you rate your overall health? Poor Fair Good Excellent

3. What are your overall fitness/wellness goals? _____

4. Describe your past strength and conditioning experiences: _____

5. Describe your aerobic/cardiovascular conditioning experiences: _____

6. Describe your current daily activity level: _____

Sedentary Low Activity Moderate Activity High Activity

7. Describe your current dietary practices: _____

Fat: no fat moderate fat high fat

Protein: low protein moderate protein high protein

Carbohydrate: low carbohydrates moderate carbohydrates high carbohydrates

Fiber: low fiber moderate fiber high fiber

8. What supplements, if any, do you use? _____

9. List any areas of body pain _____