

PN Initial Assessment & Triage Questionnaire

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NAME

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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):
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Emergency contact name:

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Emergency contact phone number:

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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?

If so, what?



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

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

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

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Have you already made changes to your habits, your health, your eating, and / or your body recently?

If so, what?



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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?

If so, approximately how many hours per week?

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

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 10-14 20 or more
 5-9 15-19

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

Do you have children? If yes, how many and what are their ages?

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

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

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

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

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

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

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

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 STRESS

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

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