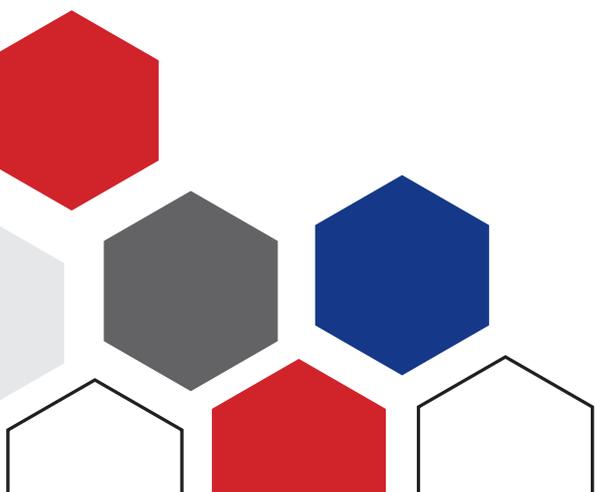


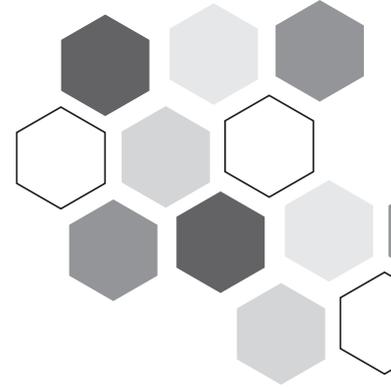


# ASSESSMENT FORMS

**TOOLS  
FOR THE  
HEALTH COACH**



# SAMPLE MEDICAL RELEASE FORM



Date \_\_\_\_\_

Dear Doctor:

Your patient, \_\_\_\_\_, wishes to start a personalized training program. The activity will involve the following:

(type, frequency, duration, and intensity of activities)

If your patient is taking medications that will affect his or her exercise capacity or heart-rate response to exercise, please indicate the manner of the effect (raises, lowers, or has no effect on exercise capacity or heart-rate response):

Type of medication(s) \_\_\_\_\_

Effect(s) \_\_\_\_\_

Please identify any recommendations or restrictions that are appropriate for your patient in this exercise program:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Thank you.  
Sincerely,

Fred Fitness  
Personalized Gym  
Address  
Phone

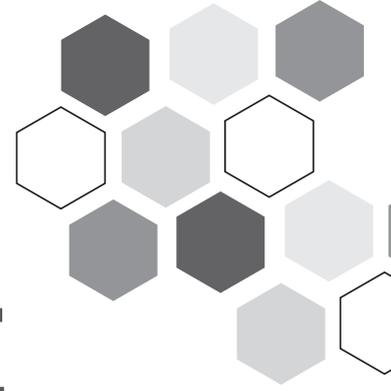
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\_\_\_\_\_ has my approval to begin an exercise program with the recommendations or restrictions stated above.

Signed \_\_\_\_\_ Date \_\_\_\_\_ Phone \_\_\_\_\_



# MUSCULOSKELETAL HEALTH QUESTIONNAIRE



1. Have you had to see a doctor in the past three years for any bone, joint, or spine problems?
  - No
  - One or two visits, but no problems now
  - Do doctors give frequent-flyer miles?
2. Have you ever had an orthopedic injury severe enough to result in one of the following?
  - Kept you out of sports or exercise for a month?
  - Required crutches for two or more weeks?
  - Required surgery?

No       Yes (to any of the questions)
3. Have you ever dislocated or separated your shoulder?

No       Yes

If yes, please explain. \_\_\_\_\_
4. Do you have joint swelling?       No       Yes
5. Have you lost mobility (range of motion) in any joint? For example, can you fully straighten (extend) and fully bend (flex)? Compare right to left.
  - No
  - A little stiff at times, but motion is full
  - Motion is limited in one or two major joints or the spine
6. Do your knees creak or make noise when you are going up or down stairs?
  - No
  - Yes, but no discomfort or pain
  - Yes, and does cause discomfort and/or pain
7. Do you have trouble actually ascending or descending stairs?
  - No
  - Only after going up and down multiple times, especially while carrying heavier items
  - Yes
8. Do you have stiffness in any joints associated with any of the following conditions?
  - Upon awakening (i.e., until showering or moving for about 15–20 minutes)
  - After sitting still for more than 30 minutes
  - For no apparent reason

No

Only the day after a hard workout

Yes
9. Does high barometric pressure (i.e., damp, rainy weather) make your joints ache?
  - No
  - Rarely
  - Friends consult me instead of the weatherman
10. Have you ever had an episode of lower-back or neck pain or spasm?
  - No
  - Yes, it kept me off my feet for less than 24 hours
  - Yes, I miss work due to recurrent episodes
11. Do you have pain while lying on either shoulder at night in bed?
  - No
  - Rarely
  - Almost nightly; tossing and turning to get comfy
12. Do you have difficulty falling asleep at night or awaken during the night because of any joint or muscle discomfort?
  - No
  - Rarely or minor difficulty
  - Yes
13. Do you awaken at night with your hands or fingers “asleep”?
  - No
  - Rarely and I easily shake it off
  - My hands get more sleep than I do

---

*Note:* If a client answers “Yes” to any of the items, this may suggest a musculoskeletal issue that warrants further evaluation. Be sure to refer to an appropriate healthcare professional as needed.



# PAR-Q AND YOU

(A Questionnaire for People Aged 15 to 69)

Regular physical activity is fun and healthy, and increasingly more people are starting to become more active every day. Being more active is very safe for most people. However, some people should check with their doctor before they start becoming much more physically active.

If you are planning to become much more physically active than you are now, start by answering the seven questions in the box below. If you are between the ages of 15 and 69, the PAR-Q will tell you if you should check with your doctor before you start. If you are over 69 years of age, and you are not used to being very active, check with your doctor.

Common sense is your best guide when you answer these questions. Please read the questions carefully and answer each one honestly: check YES or NO.

YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	1. <b>Has your doctor ever said that you have a heart condition <u>and</u> that you should only do physical activity recommended by a doctor?</b>
<input type="checkbox"/>	<input type="checkbox"/>	2. <b>Do you feel pain in your chest when you do physical activity?</b>
<input type="checkbox"/>	<input type="checkbox"/>	3. <b>In the past month, have you had chest pain when you were not doing physical activity?</b>
<input type="checkbox"/>	<input type="checkbox"/>	4. <b>Do you lose your balance because of dizziness or do you ever lose consciousness?</b>
<input type="checkbox"/>	<input type="checkbox"/>	5. <b>Do you have a bone or joint problem (for example, back, knee or hip) that could be made worse by a change in your physical activity?</b>
<input type="checkbox"/>	<input type="checkbox"/>	6. <b>Is your doctor currently prescribing drugs (for example, water pills) for your blood pressure or heart condition?</b>
<input type="checkbox"/>	<input type="checkbox"/>	7. <b>Do you know of <u>any other reason</u> why you should not do physical activity?</b>

If  
you  
answered

## YES to one or more questions

Talk with your doctor by phone or in person BEFORE you start becoming much more physically active or BEFORE you have a fitness appraisal. Tell your doctor about the PAR-Q and which questions you answered YES.

- You may be able to do any activity you want — as long as you start slowly and build up gradually. Or, you may need to restrict your activities to those which are safe for you. Talk with your doctor about the kinds of activities you wish to participate in and follow his/her advice.
- Find out which community programs are safe and helpful for you.

## NO to all questions

If you answered NO honestly to all PAR-Q questions, you can be reasonably sure that you can:

- start becoming much more physically active — begin slowly and build up gradually. This is the safest and easiest way to go.
- take part in a fitness appraisal — this is an excellent way to determine your basic fitness so that you can plan the best way for you to live actively. It is also highly recommended that you have your blood pressure evaluated. If your reading is over 144/94, talk with your doctor before you start becoming much more physically active.

### DELAY BECOMING MUCH MORE ACTIVE:

- if you are not feeling well because of a temporary illness such as a cold or a fever — wait until you feel better; or
- if you are or may be pregnant — talk to your doctor before you start becoming more active.

**PLEASE NOTE:** If your health changes so that you then answer YES to any of the above questions, tell your fitness or health professional. Ask whether you should change your physical activity plan.

Informed Use of the PAR-Q: The Canadian Society for Exercise Physiology, Health Canada, and their agents assume no liability for persons who undertake physical activity, and if in doubt after completing this questionnaire, consult your doctor prior to physical activity.

**No changes permitted. You are encouraged to photocopy the PAR-Q but only if you use the entire form.**

NOTE: If the PAR-Q is being given to a person before he or she participates in a physical activity program or a fitness appraisal, this section may be used for legal or administrative purposes.

"I have read, understood and completed this questionnaire. Any questions I had were answered to my full satisfaction."

NAME \_\_\_\_\_

SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_

SIGNATURE OF PARENT \_\_\_\_\_  
or GUARDIAN (for participants under the age of majority)

WITNESS \_\_\_\_\_

**Note: This physical activity clearance is valid for a maximum of 12 months from the date it is completed and becomes invalid if your condition changes so that you would answer YES to any of the seven questions.**



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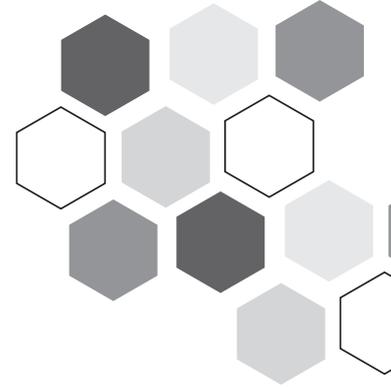


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Canada

Santé  
Canada

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# EXERCISE HISTORY AND ATTITUDE QUESTIONNAIRE

Name \_\_\_\_\_ Date \_\_\_\_\_

*General Instructions:* Please fill out this form as completely as possible. If you have any questions, DO NOT GUESS; ask your health coach for assistance.

1. Please rate your exercise level on a scale of 1 to 5 (5 indicating very strenuous) for each age range through your present age:  
15-20 \_\_\_\_\_ 21-30 \_\_\_\_\_ 31-40 \_\_\_\_\_ 41-50 \_\_\_\_\_ 51+ \_\_\_\_\_

2. Were you a high school and/or college athlete?  
 Yes  No If yes, please specify \_\_\_\_\_

3. Do you have any negative feelings toward, or have you had any bad experience with, physical-activity programs?  
 Yes  No If yes, please explain \_\_\_\_\_

4. Do you have any negative feelings toward, or have you had any bad experience with, fitness testing and evaluation?  
 Yes  No If yes, please explain \_\_\_\_\_

5. Rate yourself on a scale of 1 to 5 (1 indicating the lowest value and 5 the highest).

Circle the number that best applies.

Characterize your present athletic ability.	1	2	3	4	5
When you exercise, how important is competition?	1	2	3	4	5
Characterize your present cardiovascular capacity.	1	2	3	4	5
Characterize your present muscular capacity.	1	2	3	4	5
Characterize your present flexibility capacity.	1	2	3	4	5

6. Do you start exercise programs but then find yourself unable to stick with them?  Yes  No

7. How much time are you willing to devote to an exercise program? \_\_\_\_\_ minutes/day \_\_\_\_\_ days/week

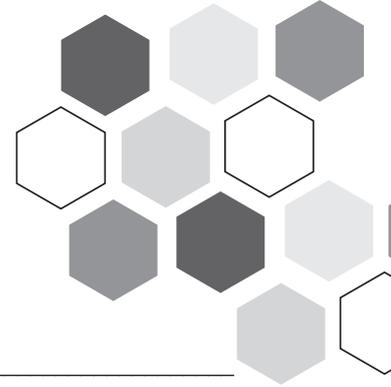
8. Are you currently involved in regular endurance (cardiovascular) exercise?  
 Yes  No If yes, specify the type of exercise(s) \_\_\_\_\_  
\_\_\_\_\_ minutes/day \_\_\_\_\_ days/week

Rate your perception of the exertion of your exercise program (check the box):

Light  Fairly light  Somewhat hard  Hard

*Continued on next page*





9. How long have you been exercising regularly? \_\_\_\_\_ months \_\_\_\_\_ years

10. What other exercise, sport, or recreational activities have you participated in?

In the past 6 months? \_\_\_\_\_

In the past 5 years? \_\_\_\_\_

11. Can you exercise during your work day?  Yes  No

12. Would an exercise program interfere with your job?  Yes  No

13. Would an exercise program benefit your job?  Yes  No

14. What types of exercise interest you?

- Walking       Jogging       Swimming       Cycling
- Aerobics       Strength training       Stationary biking       Rowing
- Racquetball       Tennis       Other aerobic activity       Stretching

15. Rank your goals in undertaking exercise: What do you want exercise to do for you?

Use the following scale to rate each goal separately.

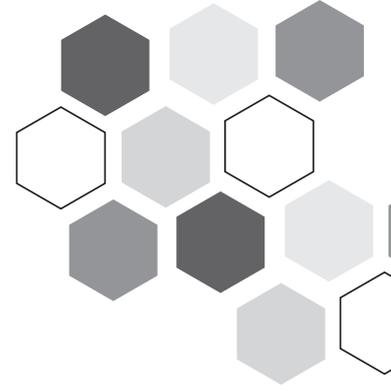
	Not at all important			Somewhat important				Extremely important		
a. Improve cardiovascular fitness	1	2	3	4	5	6	7	8	9	10
b. Facilitate body-fat weight loss	1	2	3	4	5	6	7	8	9	10
c. Reshape or tone my body	1	2	3	4	5	6	7	8	9	10
d. Improve performance for a specific sport	1	2	3	4	5	6	7	8	9	10
e. Improve moods and ability to cope with stress	1	2	3	4	5	6	7	8	9	10
f. Improve flexibility	1	2	3	4	5	6	7	8	9	10
g. Increase strength	1	2	3	4	5	6	7	8	9	10
h. Increase energy level	1	2	3	4	5	6	7	8	9	10
i. Feel better	1	2	3	4	5	6	7	8	9	10
j. Increase enjoyment	1	2	3	4	5	6	7	8	9	10
k. Other	1	2	3	4	5	6	7	8	9	10

16. By how much would you like to change your current weight?

(+) \_\_\_\_\_ lb

(-) \_\_\_\_\_ lb





# WEIGHT-LOSS READINESS QUIZ

Are you ready to lose weight? Your attitude about weight loss affects your ability to succeed. Take this Weight-loss Readiness Quiz to learn if you need to make any attitude adjustments before you begin. Mark each item true or false. Please be honest! It's important that these answers reflect the way you really are, not how you would like to be. A method for interpreting your readiness for weight loss follows:

1. \_\_\_ I have thought a lot about my eating habits and physical activities to pinpoint what I need to change.
2. \_\_\_ I have accepted the idea that I need to make permanent, not temporary, changes in my eating and activities to be successful.
3. \_\_\_ I will only feel successful if I lose a lot of weight.
4. \_\_\_ I accept the idea that it's best if I lose weight slowly.
5. \_\_\_ I'm thinking of losing weight now because I really want to, not because someone else thinks I should.
6. \_\_\_ I think losing weight will solve other problems in my life.
7. \_\_\_ I am willing and able to increase my regular physical activity.
8. \_\_\_ I can lose weight successfully if I have no "slip-ups."
9. \_\_\_ I am ready to commit some time and effort each week to organizing and planning my food and activity programs.
10. \_\_\_ Once I lose some initial weight, I usually lose the motivation to keep going until I reach my goal.
11. \_\_\_ I want to start a weight-loss program, even though my life is unusually stressful right now.

## SCORING THE WEIGHT-LOSS READINESS QUIZ

To score the quiz, look at your answers next to items 1, 2, 4, 5, 7, and 9. Score "1" if you answered "true" and "0" if you answered "false."

For items 3, 6, 8, 10, and 11, score "0" for each true answer and "1" for each false answer.

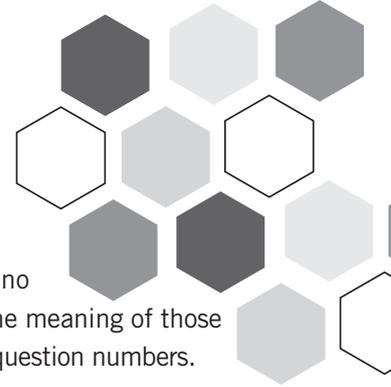
To get your total score, add the scores of all questions.

No one score indicates for sure whether you are ready to start losing weight. However, the higher your total score, the more characteristics you have that contribute to success. As a rough guide, consider the following recommendations:

1. If you scored 8 or higher, you probably have good reasons for wanting to lose weight now and a good understanding of the steps needed to succeed. Still, you might want to learn more about the areas where you scored a "0" (see "Interpretation of Quiz Items").
2. If you scored 5 to 7, you may need to reevaluate your reasons for losing weight and the methods you would use to do so. To get a start, read the advice given on the next page for those quiz items where you received a score of "0."
3. If you scored 4 or less, now may not be the right time for you to lose weight. While you might be successful in losing weight initially, your answers suggest that you are unlikely to sustain sufficient effort to lose all the weight you want, or keep off the weight that you do lose. You need to reconsider your weight-loss motivations and methods and perhaps learn more about the pros and cons of different approaches to reducing. To do so, read the advice on the next page for those quiz items where you scored "0."

*Continued on next page*





## INTERPRETATION OF QUIZ ITEMS

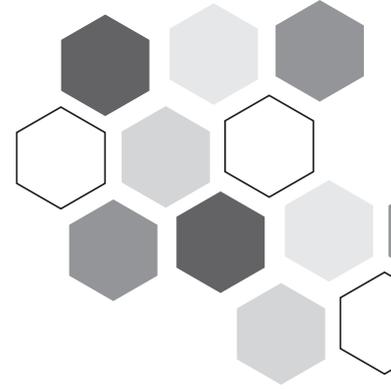
Your answers to the quiz can clue you in to potential stumbling blocks to your weight-loss success.

Any item score of “0” indicates a misconception about weight loss, or a potential problem area. While no individual item score of “0” is important enough to scuttle your weight-loss plans, you should consider the meaning of those items so that you can best prepare yourself for the challenges ahead. The numbers below correspond to the question numbers.

1. It has been said that you can't change what you don't understand. You might benefit from keeping records for a week to help pinpoint when, what, why, and how much you eat. This tool also is useful in identifying obstacles to regular physical activity.
2. Making drastic or highly restrictive changes in your eating habits may allow you to lose weight in the short-run, but be too hard to live with permanently. Similarly, your program of regular physical activity should be one you can sustain. Both your food plan and activity program should be healthful and enjoyable.
3. Most people have fantasies of reaching a weight considerably lower than they can realistically maintain. Rethink your meaning of “success.” A successful, realistic weight loss is one that can be comfortably maintained through sensible eating and regular activity. Take your body type into consideration. Then set smaller, achievable goals. Your first goal may be to lose a small amount of weight while you learn eating habits and activity patterns to help you maintain it.
4. If you equate success with fast weight loss, you will have problems maintaining your weight. This “quick fix” attitude can backfire when you face the challenges of weight maintenance. It's best—and healthiest—to lose weight slowly, while learning the strategies that allow you to keep the weight off permanently.
5. The desire for, and commitment to, weight loss must come from you. People who lose and maintain weight successfully take responsibility for their own desires and decide the best way to achieve them. Once this step is taken, friends and family are an important source of support, not motivation.
6. While being overweight may contribute to a number of social problems, it is rarely the single cause. Anticipating that all of your problems will be solved through weight loss is unrealistic and may set you up for disappointment. Instead, realize that successful weight loss will make you feel more self-confident and empowered, and that the skills you develop to deal with your weight can be applied to other areas of your life.
7. Studies have shown that people who develop the habit of regular, moderate physical activity are most successful at maintaining their weight. Exercise does not have to be strenuous to be effective for weight control. Any moderate physical activity that you enjoy and will do regularly counts. Just get moving!
8. While most people don't expect perfection of themselves in everyday life, many feel that they must stick to a weight-loss program perfectly. This is unrealistic. Rather than expecting lapses and viewing them as catastrophes, recognize them as valuable opportunities to identify problem triggers and develop strategies for the future.
9. Successful weight loss is not possible without taking the time to think about yourself, assess your problem areas, and develop strategies to deal with them. Success takes time. You must commit to planning and organizing your weight loss.
10. Do not ignore your concerns about “going the distance,” because they may indicate a potential problem. Think about past efforts and why they failed. Pinpoint any reasons, and work on developing motivational strategies to get you over those hurdles. Take your effort one day at a time; a plateau of weight maintenance within an ongoing weight-loss program is perfectly okay.
11. Weight loss itself is a source of stress, so if you are already under stress, it may be difficult to successfully implement a weight-loss program at this time. Try to resolve other stressors in your life before you begin a weight-loss effort.



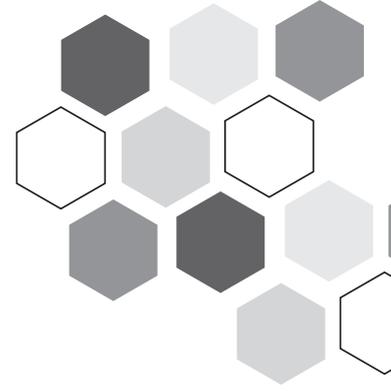
# BEHAVIORAL OUTLINE



Target behaviors	
Current daily behaviors (starting points)	Behavioral excess
	Behavioral deficits
Things triggering current behavior or preventing goal behavior?	
Self-efficacy	Stage of behavioral change
Client Preferences	Dietary
	Activity
Past Experiences	Dietary
	Activity



# BODY-COMPOSITION ASSESSMENT RESULTS



## HEIGHT, WEIGHT, AND BODY MASS INDEX

DATE: \_\_\_\_\_

Name: \_\_\_\_\_

Weight (lb): \_\_\_\_\_ Height (in): \_\_\_\_\_

If necessary, convert to metric units:

Weight in pounds x 0.454 = Weight in kg

Height in inches x 0.0254 = Height in m

Weight (kg): \_\_\_\_\_ Height (m): \_\_\_\_\_

Calculate body mass index (BMI):  $\text{Weight (kg)} / \text{Height}^2 \text{ (m)}$

BMI: \_\_\_\_\_

*Note:* Refer to page 299 for a BMI chart.

---

## CIRCUMFERENCE MEASUREMENTS

DATE: \_\_\_\_\_

Abdomen: \_\_\_\_\_

Hips: \_\_\_\_\_

Iliac: \_\_\_\_\_

Waist: \_\_\_\_\_

Waist-to-Hip Ratio:  $\text{Waist}/\text{Hip} =$  \_\_\_\_\_

---

## SKINFOLD MEASUREMENTS

DATE: \_\_\_\_\_

### MEN

Chest: \_\_\_\_\_

Abdomen: \_\_\_\_\_

Thigh: \_\_\_\_\_

Total: \_\_\_\_\_

### WOMEN

Triceps: \_\_\_\_\_

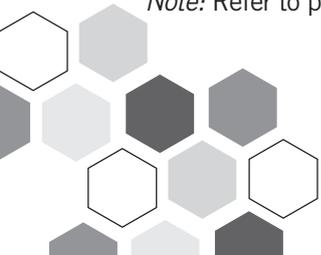
Suprailium: \_\_\_\_\_

Thigh: \_\_\_\_\_

Total: \_\_\_\_\_

% Body-fat estimation: \_\_\_\_\_

*Note:* Refer to pages 307 and 308 to determine body-fat estimates.



# PHYSICAL-FITNESS ASSESSMENT RESULTS



Name: \_\_\_\_\_

## HEART RATE

DATE: \_\_\_\_\_

Resting heart rate: \_\_\_\_\_ bpm      Exercise heart rate: \_\_\_\_\_ bpm

## BLOOD PRESSURE

DATE: \_\_\_\_\_

Resting blood pressure: \_\_\_\_/\_\_\_\_ mmHg

## VENTILATORY THRESHOLD TEST (TALK TEST) USING A TREADMILL

DATE: \_\_\_\_\_

Pre-exercise HR: \_\_\_\_\_ bpm      Pre-exercise BP (if necessary): \_\_\_\_/\_\_\_\_ mmHg

### Stage 1

HR: \_\_\_\_\_ bpm      Client assessment of discomfort \_\_\_\_\_

### Stage 2

HR: \_\_\_\_\_ bpm      Client assessment of discomfort \_\_\_\_\_

### Stage 3

HR: \_\_\_\_\_ bpm      Client assessment of discomfort \_\_\_\_\_

VT1 HR: \_\_\_\_\_ bpm

## BALKE & WARE TREADMILL EXERCISE TEST

DATE: \_\_\_\_\_

Pre-exerciser HR: \_\_\_\_\_ bpm

Estimate of submaximal target HR (Maximum heart rate x 0.85): \_\_\_\_\_ bpm

Minute 1	HR: _____ bpm	RPE: _____	BP: _____ mmHg
Minute 2	HR: _____ bpm	RPE: _____	BP: _____ mmHg
Minute 3	HR: _____ bpm	RPE: _____	BP: _____ mmHg
Minute 4	HR: _____ bpm	RPE: _____	BP: _____ mmHg
Minute 5	HR: _____ bpm	RPE: _____	BP: _____ mmHg
Minute 6	HR: _____ bpm	RPE: _____	BP: _____ mmHg
Minute 7	HR: _____ bpm	RPE: _____	BP: _____ mmHg
Minute 8	HR: _____ bpm	RPE: _____	BP: _____ mmHg
Minute 9	HR: _____ bpm	RPE: _____	BP: _____ mmHg
Minute 10	HR: _____ bpm	RPE: _____	BP: _____ mmHg
Minute 11	HR: _____ bpm	RPE: _____	BP: _____ mmHg
Minute 12	HR: _____ bpm	RPE: _____	BP: _____ mmHg
Minute 13	HR: _____ bpm	RPE: _____	BP: _____ mmHg
Minute 14	HR: _____ bpm	RPE: _____	BP: _____ mmHg
Minute 15	HR: _____ bpm	RPE: _____	BP: _____ mmHg
Minute 16	HR: _____ bpm	RPE: _____	BP: _____ mmHg

Time until completion \_\_\_\_\_ minutes

Calculate estimated  $\dot{V}O_{2max}$ :

For men:  $\dot{V}O_{2max} = 1.444$   
(time in minutes) + 14.99

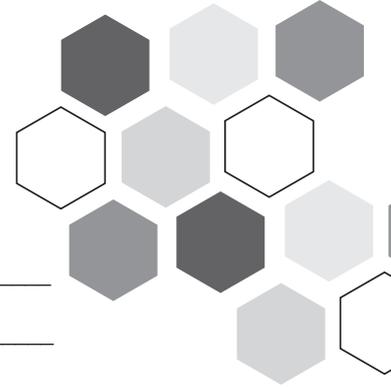
For women:  $\dot{V}O_{2max} = 1.38$   
(time in minutes) + 5.22

Estimated  $\dot{V}O_{2max}$ : \_\_\_\_\_

To calculate METs, divide  $\dot{V}O_{2max}$   
by 3.5 mL/kg/min

METs: \_\_\_\_\_





**ROCKPORT FITNESS WALKING TEST (1 MILE)**

**DATE:** \_\_\_\_\_

1-mile time: \_\_\_\_\_

Steady-state heart rate: \_\_\_\_\_ bpm

RPE: \_\_\_\_\_

Weather: \_\_\_\_\_

Location: \_\_\_\_\_

Surface area: \_\_\_\_\_

Other: \_\_\_\_\_

**Calculate  $\dot{V}O_2$ :**

Females:  $\dot{V}O_2$  (mL/kg/min) = 132.853 – (0.1692 x Weight in kg) – (0.3877 x Age) – (3.265 x Walk time, expressed in minutes to the nearest 100th) – (0.1565 x HR)

Males:  $\dot{V}O_2$  (mL/kg/min) = 139.168 – (0.1692 x Weight in kg) – (0.3877 x Age) – (3.265 x Walk time, expressed in minutes to the nearest 100th) – (0.1565 x HR)

$\dot{V}O_2$ : \_\_\_\_\_

Performance rating: \_\_\_\_\_

*Note:* Refer to page 336 to determine performance rating.

**STATIC POSTURAL ASSESSMENT**

**DATE:** \_\_\_\_\_

Notes: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**STORK-STAND BALANCE TEST**

**DATE:** \_\_\_\_\_

Time to completion: \_\_\_\_\_ Reason for stopping: \_\_\_\_\_

Performance rating: \_\_\_\_\_

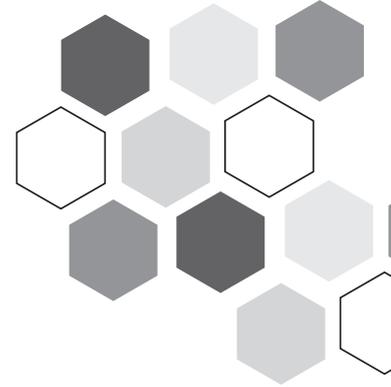
*Note:* Refer to page 343 to determine performance rating.

**SHARPENED ROMBERG TEST**

**DATE:** \_\_\_\_\_

Time to completion: \_\_\_\_\_ Reason for stopping: \_\_\_\_\_





**MCGILL'S TORSO MUSCULAR ENDURANCE TEST BATTERY**

DATE: \_\_\_\_\_

*Trunk flexor endurance test:*

Time to completion: \_\_\_\_\_

*Trunk lateral endurance test:*

Right side

Time to completion: \_\_\_\_\_

Left side

Time to completion: \_\_\_\_\_

*Trunk extensor endurance test:*

Time to completion: \_\_\_\_\_

Flexion/extension ratio: \_\_\_\_\_

Right-side bridge/left-side bridge ratio: \_\_\_\_\_

Side-bridge (either side)/extension ratio: \_\_\_\_\_

**MODIFIED BODY-WEIGHT SQUAT**

DATE: \_\_\_\_\_

Depth of squat: \_\_\_\_\_ degrees

Number of repetitions: \_\_\_\_\_

Where does the client report feeling the muscles working the most? \_\_\_\_\_

Knee alignment from anterior view: \_\_\_\_\_

**FRONT PLANK**

DATE: \_\_\_\_\_

Time to completion \_\_\_\_\_

Where does the client report feeling the muscles working the most? \_\_\_\_\_

**OVERHEAD REACH**

DATE: \_\_\_\_\_

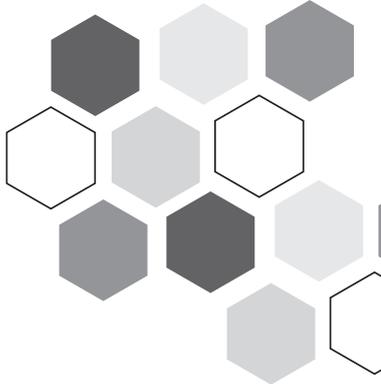
Do the thumbs touch the floor? \_\_\_\_\_

Does the client arch the back? \_\_\_\_\_

Analysis of shoulder flexibility (adequate/inadequate): \_\_\_\_\_



# DECISIONAL BALANCE WORKSHEET



BEHAVIOR	DISADVANTAGES	ADVANTAGES





# LIFESTYLE AND HEALTH-HISTORY QUESTIONNAIRE

## MEDICAL INFORMATION

- How would you describe your present state of health?  very well  healthy  unhealthy  ill  other: \_\_\_\_\_
- Are you taking any prescription medication?  Yes  No  
If yes, what medications and why? \_\_\_\_\_  
Do these interact with foods or weight loss in any way? \_\_\_\_\_
- Do you take any over-the-counter medication?  Yes  No  
If yes, what medications and why? \_\_\_\_\_
- When was the last time you visited your physician? \_\_\_\_\_
- Have you ever had your cholesterol checked?  Yes  No  
Date of test: \_\_\_\_\_ What were the results?  
Total Cholesterol: \_\_\_\_\_ HDL: \_\_\_\_\_ LDL: \_\_\_\_\_ TG: \_\_\_\_\_
- Have you ever had your blood sugar checked?  Yes  No  
What were the results? \_\_\_\_\_
- Please check any that apply to you and list any important information about your condition:
 

<input type="checkbox"/> Allergies (Specify: _____)	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Premenstrual syndrome (PMS)
<input type="checkbox"/> Amenorrhea	<input type="checkbox"/> Disordered eating	<input type="checkbox"/> Polycystic ovary syndrome (PCOS)
<input type="checkbox"/> Anemia	<input type="checkbox"/> Gastroesophageal reflux disease (GERD)	<input type="checkbox"/> Pregnant
<input type="checkbox"/> Anxiety	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Ulcer
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Hypoglycemia	<input type="checkbox"/> Skin problems
<input type="checkbox"/> Asthma	<input type="checkbox"/> Hypo/hyperthyroidism	<input type="checkbox"/> Major surgeries: _____
<input type="checkbox"/> Celiac disease	<input type="checkbox"/> Insomnia	<input type="checkbox"/> Past injuries: _____
<input type="checkbox"/> Chronic sinus condition	<input type="checkbox"/> Intestinal problems	<input type="checkbox"/> Describe any other health conditions that you have: _____
<input type="checkbox"/> Constipation	<input type="checkbox"/> Irritability	_____
<input type="checkbox"/> Crohn's disease	<input type="checkbox"/> Irritable bowel syndrome (IBS)	_____
<input type="checkbox"/> Depression	<input type="checkbox"/> Menopausal symptoms	_____
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Osteoporosis	_____

## FAMILY HISTORY

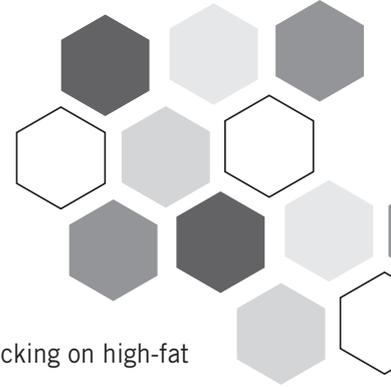
- Has anyone in your immediate family been diagnosed with the following?
 

<input type="checkbox"/> Heart disease	If yes, what is the relation: _____	Age of diagnosis: _____
<input type="checkbox"/> High cholesterol	If yes, what is the relation: _____	Age of diagnosis: _____
<input type="checkbox"/> High blood pressure	If yes, what is the relation: _____	Age of diagnosis: _____
<input type="checkbox"/> Cancer	If yes, what is the relation: _____	Age of diagnosis: _____
<input type="checkbox"/> Diabetes	If yes, what is the relation: _____	Age of diagnosis: _____
<input type="checkbox"/> Osteoporosis	If yes, what is the relation: _____	Age of diagnosis: _____
- What are your dietary goals? \_\_\_\_\_
- Have you ever followed a modified diet?  Yes  No  
If so, describe: \_\_\_\_\_
- Are you currently following a specialized diet (e.g., low-sodium or low-fat)?  Yes  No  
If so, what type of diet? \_\_\_\_\_

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Note: HDL = High-density lipoprotein; LDL = Low-density lipoprotein; TG = Triglycerides





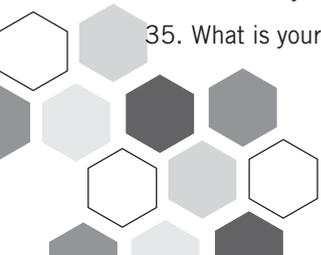
12. Why did you choose this diet? \_\_\_\_\_  
 Was the diet prescribed by a physician?  Yes  No  
 How long have you been on the diet? \_\_\_\_\_
13. Have you ever met with a registered dietitian?  Yes  No  
 Are you interested in meeting with one?  Yes  No
14. What do you consider to be the major issues in your diet and eating plan? (e.g., eating late at night, snacking on high-fat foods, skipping meals, or lack of variety) \_\_\_\_\_
15. How many glasses of water do you drink per day? \_\_\_\_\_ 8-ounce glasses
16. Do you have any food allergies or intolerance?  Yes  No  
 If so, what? \_\_\_\_\_
17. Who prepares your food?  Self  Spouse  Parent  Minimal preparation
18. How often do you dine out? \_\_\_\_\_ times per week
19. Please specify the type of restaurants for each meal:  
 Breakfast: \_\_\_\_\_ Lunch: \_\_\_\_\_  
 Dinner: \_\_\_\_\_ Snacks: \_\_\_\_\_

**HABITS**

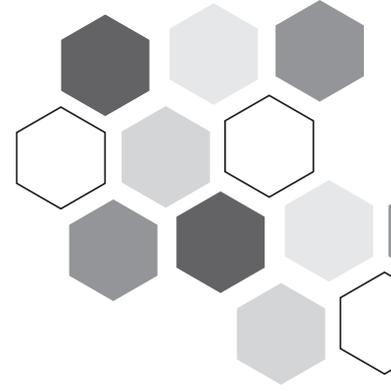
20. Do you crave any foods?  Yes  No  
 If so, please specify: \_\_\_\_\_
21. How is your appetite affected by stress?  increased  not affected  decreased
22. Do you drink alcohol?  Yes  No How often? \_\_\_\_\_ times per week Average amount? \_\_\_\_\_ glasses
23. Do you drink caffeinated beverages?  Yes  No Average number per day: \_\_\_\_\_
24. Do you use tobacco?  Yes  No How much (cigarettes, cigars, or chewing tobacco per day)? \_\_\_\_\_
25. Do you take any vitamin, mineral, or herbal supplements?  Yes  No  
 Please list type and amount per day: \_\_\_\_\_
26. Do you currently participate in any structured physical activity?  Yes  No  
 If so, please describe: \_\_\_\_\_ minutes of cardiovascular activity, \_\_\_\_\_ times per week  
 \_\_\_\_\_ strength-training sessions, \_\_\_\_\_ times per week  
 \_\_\_\_\_ minutes of flexibility training, \_\_\_\_\_ times per week  
 \_\_\_\_\_ minutes of sports per week  
 List sports: \_\_\_\_\_  
 Do you engage in any other forms of regular physical activity? \_\_\_\_\_  
 Please describe your activity level during the work day: \_\_\_\_\_
27. Have you experienced any injuries that may limit your physical activity?  
 If so, please describe: \_\_\_\_\_
28. On a scale of 1–10, how ready are you to adopt a healthier lifestyle? 1 = very unlikely 10 = very likely \_\_\_\_\_

**WEIGHT HISTORY**

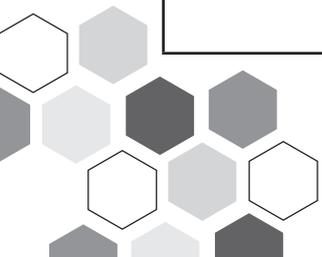
29. What would you like to do with your weight?  lose weight  gain weight  maintain weight
30. What was your lowest weight within the past 5 years? \_\_\_\_\_ lb
31. What was your highest weight within the past 5 years? \_\_\_\_\_ lb
32. What do you consider to be your ideal weight (the weight at which you feel best)? \_\_\_\_\_ lb  don't know
33. What is your present weight? \_\_\_\_\_ lb
34. What are your current waist and hip circumferences? \_\_\_\_\_ waist \_\_\_\_\_ hip  don't know
35. What is your present body composition? \_\_\_\_\_ % body fat  don't know



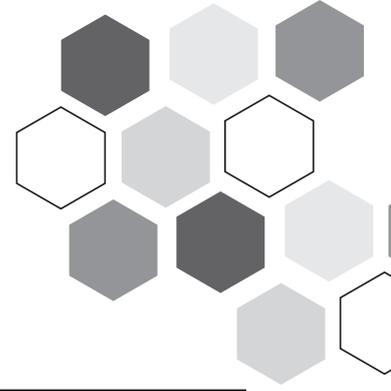
# FOOD DIARY/RECORD



	MEAL/SNACK TIME	FOOD/BEVERAGE & AMOUNT	FOOD GROUP SERVINGS	HUNGER LEVEL	MOOD/THOUGHTS	LOCATION	CHALLENGES
BREAKFAST							
SNACK							
LUNCH							
SNACK							
DINNER							

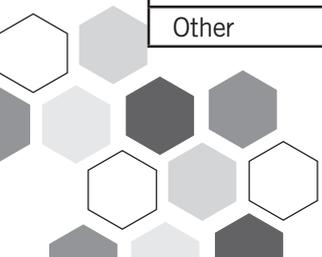


# FOOD-FREQUENCY QUESTIONNAIRE



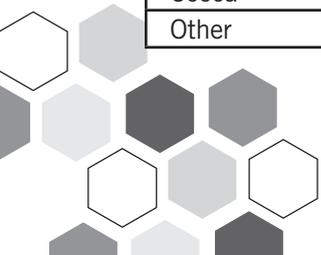
FOOD	EVERY DAY (ALWAYS)	3 OR 4 TIMES/WEEK (OFTEN)	EVERY 2 OR 3 WEEKS (SOMETIMES)	DON'T EAT (NEVER)
Dairy Products				
Milk, whole				
Milk, reduced fat				
Milk, nonfat				
Cottage cheese				
Cream cheese				
Other cheeses				
Yogurt				
Ice cream				
Sherbet				
Puddings				
Margarine				
Butter				
Other				
Meats				
Beef, hamburger				
Poultry				
Pork, ham				
Bacon, sausage				
Cold cuts, hot dogs				
Other				
Fish				
Canned tuna				
Breaded fish				
Fresh or frozen fish				
Eggs				
Peanut butter				
Grain products				
Bread, white				
Bread, whole wheat				
Rolls, muffins				
Pancakes, waffles				
Bagels				
Pasta, spaghetti				
Pasta, macaroni and cheese				
Rice				
Crackers				
Other				

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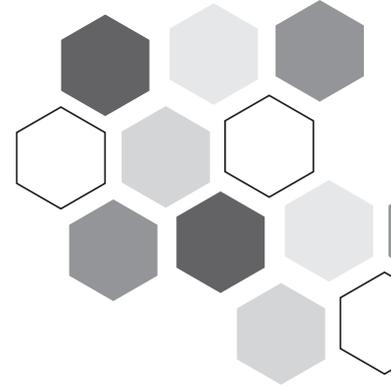




FOOD	EVERY DAY (ALWAYS)	3 OR 4 TIMES/WEEK (OFTEN)	EVERY 2 OR 3 WEEKS (SOMETIMES)	DON'T EAT (NEVER)
Cereals				
Sugar-coated				
High-fiber (bran)				
Natural (granola)				
Plain (e.g., Cheerios®)				
Fortified				
Other				
Fruits				
Oranges, orange juice				
Tomatoes, tomato juice				
Grapefruit, grapefruit juice				
Strawberries				
Cranberry juice				
Apples, apple juice				
Grapes, grape juice				
Fruit drink				
Peaches				
Bananas				
Other				
Vegetables				
Peppers				
Potatoes				
Lettuce				
Broccoli				
Spinach				
Carrots				
Corn				
Squash				
Peas				
Green beans				
Beets				
Other				
Snacks and Sweets				
Chips (potato, corn)				
Pretzels				
Popcorn				
French fries				
Cookies				
Pastries				
Candy				
Sugar, honey, jelly				
Soda, regular				
Soda, diet				
Cocoa				
Other				



# BEHAVIORAL CONTRACT



Behavioral contracting is an effective behavior-modification strategy. In behavioral contracting for exercise adherence, the health coach and the client set up a system of rewards for sticking to the lifestyle-modification program. Behavioral contracting is most effective when the rewards are outlined by, and meaningful to, the client. If the rewards are not meaningful, the client may not find them to be worth working toward. Behavioral contracting works differently for each individual and health coaches have to be careful not to push certain rewards on clients. Additionally, behavioral contracting is most effective when it is used consistently. Once certain goals are met, contracts need to be reconstructed throughout the duration of program participation.

Below are the elements of a typical behavioral contract.

**I Will:** (Do what) \_\_\_\_\_  
(When) \_\_\_\_\_  
(How often) \_\_\_\_\_  
(How much) \_\_\_\_\_

How confident am I that I will do this? \_\_\_\_\_ (on a scale of 0 to 10, with 0 being not at all confident and 10 being completely confident)

If I successfully make this positive lifestyle change by \_\_\_\_\_, I will reward myself with \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_.

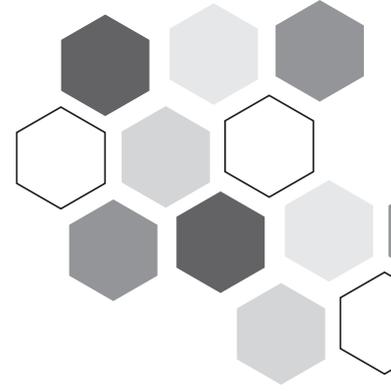
If I fail to successfully make this positive lifestyle change, I will forfeit this reward.

I, \_\_\_\_\_, have reviewed this contract and I agree to discuss  
the experience involved in accomplishing or not accomplishing this health behavior improvement with  
\_\_\_\_\_ on \_\_\_\_\_.

Signed (Client): \_\_\_\_\_

Signed (Health Coach): \_\_\_\_\_





# READINESS TO CHANGE QUESTIONNAIRE

	YES	NO
Are you looking to change a specific behavior?	<input type="checkbox"/>	<input type="checkbox"/>
Are you willing to make this behavioral change a top priority?	<input type="checkbox"/>	<input type="checkbox"/>
Have you tried to change this behavior before?	<input type="checkbox"/>	<input type="checkbox"/>
Do you believe there are inherent risks/dangers associated with not making this behavioral change?	<input type="checkbox"/>	<input type="checkbox"/>
Are you committed to making this change, even though it may prove challenging?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have support for making this change from friends, family, and loved ones?	<input type="checkbox"/>	<input type="checkbox"/>
Besides health reasons, do you have other reasons for wanting to change this behavior?	<input type="checkbox"/>	<input type="checkbox"/>
Are you prepared to be patient with yourself if you encounter obstacles, barriers, and/or setbacks?	<input type="checkbox"/>	<input type="checkbox"/>



## **OUR MISSION:**

**ACE is a nonprofit organization committed to enriching quality of life through safe and effective exercise and physical activity. We protect all segments of society against ineffective fitness products, programs and trends through ongoing public education, outreach and independent, science-based research. We take that protection a step further by setting certification and continuing education standards that help ensure consumers are getting sound, quality advice from qualified fitness professionals.**



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