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

______________________________________________________________________ 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.

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
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<tbody>
<tr>
<td>☐</td>
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<tr>
<td>1. Has your doctor ever said that you have a heart condition and that you should only do physical activity recommended by a doctor?</td>
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<tr>
<td>2. Do you feel pain in your chest when you do physical activity?</td>
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<tr>
<td>3. In the past month, have you had chest pain when you were not doing physical activity?</td>
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<tr>
<td>4. Do you lose your balance because of dizziness or do you ever lose consciousness?</td>
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<td>5. 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?</td>
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<td>6. Is your doctor currently prescribing drugs (for example, water pills) for your blood pressure or heart condition?</td>
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<tr>
<td>7. Do you know of any other reason why you should not do physical activity?</td>
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</table>

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.

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

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

NAME ____________________________

SIGNATURE ________________________

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

DATE ____________________________

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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**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.

    a. Improve cardiovascular fitness
    b. Facilitate body-fat weight loss
    c. Reshape or tone my body
    d. Improve performance for a specific sport
    e. Improve moods and ability to cope with stress
    f. Improve flexibility
    g. Increase strength
    h. Increase energy level
    i. Feel better
    j. Increase enjoyment
    k. Other

                  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
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

<table>
<thead>
<tr>
<th>Target behaviors</th>
<th>Current daily behaviors (starting points)</th>
<th>Behavioral excess</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Behavioral deficits</td>
</tr>
<tr>
<td>Things triggering current behavior or preventing goal behavior?</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Self-efficacy</td>
<td>Stage of behavioral change</td>
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<tr>
<td></td>
<td>Client Preferences</td>
<td>Dietary</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Activity</td>
</tr>
<tr>
<td>Past Experiences</td>
<td>Dietaty</td>
<td>Activity</td>
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</tbody>
</table>
BODY-COMPOSITION ASSESSMENT RESULTS

HEIGHT, WEIGHT, AND BODY MASS INDEX

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): Weight (kg) / Height² (m)

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

CIRCUMFERENCE MEASUREMENTS

DATE: ___________________

Abdomen: _______________  Hips: _______________
Iliac: _______________  Waist: _______________

Waist-to-Hip Ratio: Waist/Hip = _______________

SKINFOLD MEASUREMENTS

DATE: ___________________

MEN

WOMEN

Chest: _______________  Triceps: _______________
Abdomen: _______________  Suprailium: _______________
Thigh: _______________  Thigh: _______________

Total: _______________  Total: _______________

% Body-fat estimation: _______________

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

HEART RATE
Resting heart rate: _______________ bpm  Exercise heart rate: _______________ bpm

BLOOD PRESSURE
Resting blood pressure: ____/____ mmHg

VENTILATORY THRESHOLD TEST (TALK TEST) USING A TREADMILL
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
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 $\dot{V}O_2\text{max}$:
For men: $\dot{V}O_2\text{max} = 1.444 \times (time in minutes) + 14.99$
For women: $\dot{V}O_2\text{max} = 1.38 \times (time in minutes) + 5.22$
Estimated $\dot{V}O_2\text{max}$: ______________

To calculate METs, divide $\dot{V}O_2\text{max}$ 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: _______________
Left side: _______________
Time to completion: _______________ 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

<table>
<thead>
<tr>
<th>Behavior</th>
<th>Disadvantages</th>
<th>Advantages</th>
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(continued on next page)
LIFESTYLE AND HEALTH-HISTORY QUESTIONNAIRE

MEDICAL INFORMATION

1. How would you describe your present state of health? □ very well □ healthy □ unhealthy □ ill □ other:__________

2. 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? __________________________

3. Do you take any over-the-counter medication? □ Yes □ No
   If yes, what medications and why? ____________________________________________

4. When was the last time you visited your physician? ____________________________

5. Have you ever had your cholesterol checked? □ Yes □ No
   Date of test:______________________ What were the results?
   Total Cholesterol:____________   HDL:___________ LDL:___________ TG:___________

6. Have you ever had your blood sugar checked? □ Yes □ No
   What were the results?___________________

7. Please check any that apply to you and list any important information about your condition:
   □ Allergies  □ Diarrhea  □ Premenstrual syndrome (PMS)
   (Specify:_______________ ) □ Disordered eating □ Polycystic ovary syndrome (PCOS)
   □ Amenorrhea □ Gastroesophageal reflux disease □ Pregnant 
   (GERD) □ High blood pressure □ Ulcer
   □ Anemia □ Hypoglycemia □ Skin problems
   □ Anxiety □ Hypo/hyperthyroidism □ Major surgeries:_________________________
   □ Arthritis □ Intestinal problems □ Past injuries:____________________________
   □ Asthma □ Irritability □ Describe any other health conditions
   □ Celiac disease □ Irritable bowel syndrome (IBS) that you have:_________________
   □ Chronic sinus condition □ Menopausal symptoms
   □ Constipation □ Osteoporosis
   □ Crohn’s disease
   □ Depression
   □ Diabetes

FAMILY HISTORY

8. Has anyone in your immediate family been diagnosed with the following?
   □ Heart disease  If yes, what is the relation:___________________________  Age of diagnosis:________
   □ High cholesterol  If yes, what is the relation:__________________________  Age of diagnosis:________
   □ High blood pressure  If yes, what is the relation:_______________________  Age of diagnosis:________
   □ Cancer  If yes, what is the relation:____________________________________  Age of diagnosis:________
   □ Diabetes  If yes, what is the relation:___________________________________  Age of diagnosis:________
   □ Osteoporosis  If yes, what is the relation:_______________________________  Age of diagnosis:________

9. What are your dietary goals? ________________________________________________

10. Have you ever followed a modified diet? □ Yes □ No
    If so, describe:__________________________________________________________

11. Are you currently following a specialized diet (e.g., low-sodium or low-fat)? □ Yes □ No
    If so, what type of diet? _________________________________________________
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

<table>
<thead>
<tr>
<th>MEAL/SNACK TIME</th>
<th>FOOD/Beverage &amp; AMOUNT</th>
<th>FOOD GROUP SERVINGS</th>
<th>HUNGER LEVEL</th>
<th>MOOD/THOUGHTS</th>
<th>LOCATION</th>
<th>CHALLENGES</th>
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<tbody>
<tr>
<td>BREAKFAST</td>
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<td>DINNER</td>
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## FOOD-FREQUENCY QUESTIONNAIRE

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<tr>
<th>FOOD</th>
<th>EVERY DAY (ALWAYS)</th>
<th>3 OR 4 TIMES/WEEK (OFten)</th>
<th>EVERY 2 OR 3 WEEKS (SOMETIMES)</th>
<th>DON’T EAT (NEVER)</th>
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<tbody>
<tr>
<td>Dairy Products</td>
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<tr>
<td>Milk, whole</td>
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<tr>
<td>Milk, reduced fat</td>
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<tr>
<td>Milk, nonfat</td>
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<tr>
<td>Cottage cheese</td>
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<tr>
<td>Cream cheese</td>
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<td>Other cheeses</td>
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<tr>
<td>Yogurt</td>
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<td>Ice cream</td>
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<tr>
<td>Sherbet</td>
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<td>Fresh or frozen fish</td>
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<th>FOOD</th>
<th>EVERY DAY (ALWAYS)</th>
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<th>EVERY 2 OR 3 WEEKS (SOMETIMES)</th>
<th>DON'T EAT (NEVER)</th>
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<td>Green beans</td>
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<td>Beets</td>
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<tr>
<td>Snacks and Sweets</td>
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<td>Chips (potato, corn)</td>
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<td>Pastries</td>
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<tr>
<td>Candy</td>
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<tr>
<td>Sugar, honey, jelly</td>
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<td>Soda, regular</td>
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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

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
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<tbody>
<tr>
<td>Are you looking to change a specific behavior?</td>
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<tr>
<td>Are you willing to make this behavioral change a top priority?</td>
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<tr>
<td>Have you tried to change this behavior before?</td>
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<tr>
<td>Do you believe there are inherent risks/dangers associated with not making this behavioral change?</td>
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<tr>
<td>Are you committed to making this change, even though it may prove challenging?</td>
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<tr>
<td>Do you have support for making this change from friends, family, and loved ones?</td>
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<tr>
<td>Besides health reasons, do you have other reasons for wanting to change this behavior?</td>
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<tr>
<td>Are you prepared to be patient with yourself if you encounter obstacles, barriers, and/or setbacks?</td>
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</table>
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.