**Healthy Lifestyle and Fitness Coaching**

**Diabetes Management and Disease Prevention Program**

All information received on this form will be treated as strictly confidential. Please fill out the form ***completely and accurately***. This information is essential to helping the nutritionist develop a wellness program that addresses your needs, goals and interests and is safe and effective.

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| Have you ever been seen in the DIHFS medical clinic before? Do you already have a medical history on file?  | ☐ Yes ☐ No☐ Yes ☐ No |

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| **Demographics** |
| Full Name |  | Gender | ☐Male☐ Female |
| Date of Birth |  | Age |  |
| Mailing Address |  |
| Phone # | ☐home☐work ☐ cell |
| Email Address |  |
| Occupation/work |  |
| Family Status | ☐single ☐dating ☐married ☐divorced/separated☐widowed☐children |

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| **Concerns** |
| What health/ fitness concerns would you like to focus on during your visit? |
| **1** |  |
| **2** |  |
| **3** |  |

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| **Medications and Supplements** |
| Medication Name | Year Started | Dose/Frequency | Reason |
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| **Lifestyle Information** |
| How many hours do you sleep on weeknights? ☐<6 ☐ 6-8 ☐8-10☐ 10+ |
| How many hours do you sleep on weekends? ☐<6 ☐ 6-8 ☐8-10☐ 10+ |
| Check which apply to you: ☐ Trouble falling asleep ☐Wake up during the night ☐Don’t feel rested |
| Do you smoke? | ☐ No☐ Yes; how many cigarettes per day/week? |
| Do you drink alcohol? | ☐ No☐ Yes; how many drinks per day/week? |
| **How important is it for you to be physically active?** ☐ Not important          ☐ Somewhat important          ☐ Very important  |

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| **Traditional Movement** |
| **Are you familiar with traditional forms of movement?** ☐No ☐ Yes;  |
| **If Yes** -- What does “traditional movement” mean to you? |
| **Did you participate in traditional movement growing up?** ☐No ☐ Yes; |
| **If Yes** -- What types of traditional movement did you participate in growing up? |
| **Do you participate in traditional movements now?** ☐No ☐ Yes; |
| **If Yes** – What types of traditional movements do you participate in now? |
| **How important is it for you to participate in traditional movements?**☐Not important☐Somewhat important ☐Very important |

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| **Nutrition History** |
| Have you ever had an appointment with a dietitian or nutritionist?  | ☐ No☐ Yes |
| Are you currently following a particular diet or nutrition plan? ☐ No☐ Yes; please describe |
| Do you avoid any particular foods? ☐ No☐ Yes; please describe |

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| **Nutrition History**  |
| Height: | Weight: | Usual Weight: | Desired weight: |
| Have you recently lost or gained weight?  |  ☐ No☐ Yes; please describe |
| Do you have, or have you had, an eating disorder?  |  ☐ No☐ Yes; please describe |
| Meals per day?  | Snacks per day? |
| How many meals do you “eat out” per week? ☐ 0-1☐ 2-3 ☐ 4-5 ☐ 6+ |

**CARDIOVASCULAR RISK FACTORS**

If you check TWO OR MORE of the statements in the section below, we may require medical clearance from your physician/health care provider before making exercise recommendations.

⃝ You are a man older than 45 years.

⃝ You are a woman older than 55 years or you have had a hysterectomy, or you are postmenopausal.

⃝ You smoke, or you have quit smoking within the previous 6 months.

⃝ Your blood pressure is greater than 140/90 or you don’t know if your blood pressure is normal.

⃝ You take blood pressure medication

⃝ Your blood cholesterol level is > 200 mg/dl or you don’t know your blood cholesterol level.

⃝ You have a close relative who had a heart attack before the age of 55 (father or brother) or before age 65 (mother or sister).

⃝ You are managing diabetes or take medicine to control your blood sugar.

⃝ You are physically inactive (i.e. you get less than 30 minutes of physical activity on at least 3 days per week.)

**PAIN AND DISCOMFORT**

Please list your previous injuries:

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Darken the area on the body where you are

having problems:

Location of Pain/Injury? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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When did the problem become worse?

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

What is your pain at rest?

1 2 3 4 5 6 7 8 9 10

(no pain) (worst pain)

What is your pain with activity?

1 2 3 4 5 6 7 8 9 10

(no pain) (worst pain)

Have you tried to reduce pain before?

**READINESS TO CHANGE**

|  |  |
| --- | --- |
|  |  **Yes No** |
| Are you looking to change a specific behavior? | ⃝ ⃝ |
| Are you willing to make this behavioral change a top priority? | ⃝ ⃝ |
| Have you tried to change this behavior before? | ⃝ ⃝ |
| Do you believe there are risks associated with not making a change? | ⃝ ⃝ |
| Are you committed to making this change, even though it may prove challenging? | ⃝ ⃝ |
| Are you prepared to be patient if encountering obstacles and/or setbacks?  | ⃝ ⃝ |
| Do you have support for making this change? Please list who: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | ⃝ ⃝ |

**EXERCISE PREFERENCE**

What would you like to achieve with an exercise program? Check all that apply.

|  |  |  |
| --- | --- | --- |
| ⃝ Lose weight  | ⃝ Diabetes Management | ⃝ Management depression |
| ⃝ Gain weight | ⃝ Blood pressure control | ⃝ Reduce anxiety |
| ⃝ Decrease body fat | ⃝ Heart health | ⃝ Increase flexibility |
| ⃝ Increase muscle mass | ⃝ Reduce stress |  |
| ⃝ Injury rehab | ⃝ Sleep better | ⃝ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**DEVELOPING YOUR PLAN**

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| --- | --- |
| How many days per week do you plan to commit to exercise? |  |
| How much time do you have per exercise session?  |  |
| What days and times do you prefer to exercise? |  |

**GOAL SETTING**

Writing down goals can help you to visualize and assess the commitments needed to work towards a healthy fitness goal. Which goals are most important to you?

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| --- | --- |
| Commitment/Goal #1: |  |
| Commitment/Goal #2: |  |
| Commitment/Goal #3: |  |

**Informed Consent**

Informed Consent for Participation in Personal Training with the Diabetes Prevention Specialist.

Prior to meeting with the Healthy Lifestyle Coach, you will be asked to enroll as a patient in the clinic, complete a physical activity readiness questionnaire (PAR-Q), and an exercise history and preferences sheet. The information you provide will be reviewed with you by the Diabetes Prevention Specialist. It will be used to help determine whether a medical clearance is necessary before recommending new fitness activities.

Information about your current, previous, and future health status may affect the safety and value of your exercise program. You are responsible for disclosing such information on health questionnaires. If you have any medical conditions or other underlying concerns which are not covered on the forms, you are responsible for informing the Diabetes Prevention Specialist.

If your health status changes at any time, it should be reported back to the Diabetes Prevention Specialist and your doctor before continuing exercise, as the recommendations given at any time of your fitness consultation may not apply. Likewise, during exercise participation, it is important to notice any sensations, symptoms, or feelings that concern you and to discuss these with the DPS and/or a doctor before continuing exercise.

The information being gathered will be treated as privileged and confidential and will not be released to anyone other than program staff without your permission.

**Benefits to be expected:** The benefits of engaging in regular exercise include increased energy and improved physical, psychological, and mental well-being, as well as weight-management.

There is evidence that regular physical activity is related to a lower risk of and improved management of a variety of health problems including anxiety, atherosclerosis, hypertension, heart disease, lung disease, diabetes, osteoporosis, stroke, cancer, depression, obesity and back pain. My participation in this Personal Training program is completely voluntary.

I have read this form and understand the risks involved with participation in an exercise program. I understand that I can discontinue participation in any or all aspects of the fitness program at any time. I understand that if I have further questions or concerns, I may ask for more information.

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| --- | --- | --- | --- | --- |
|  |  |  |  |  |
| **Name** |  | **Signature** |  | **Date** |

*Please bring this completed form to your first visit!*