

## TERRIO Lifestyle Health/Nutrition Pre-Screen

<b>Name:</b>				<b>Date:</b>			
	<b>Sex:</b> M F	<b>Body Frame:</b> S M L	<b>Age:</b>	<b>Height/Weight:</b>			
<b>Address:</b>							<b>Zip Code:</b>
<b>Phone Num.:</b>	<b>Home:</b>	<b>Work:</b>		<b>Cell:</b>			
<b>Email:</b>							
<b>Physician:</b>				<b>Physician phone number:</b>			
<b>Emergency Contact:</b>	<b>Phone number:</b>						

*Office use only:*                      *Recommended program:*    *Start Date:*  
*Nutrition counselor assigned:*    *Fitness trainer assigned:*

### LIFESTYLE:

<b>Exercise History:</b>	
<b>Are you seeing good results with your current workout?</b>	
<b>What hours are you available to attend meetings?</b>	Day(s)    M    T    W    Th    F    Sat Time(s)   morning                      afternoon                      evening
<b>Do you consider yourself to have a healthy lifestyle? Why or Why not?</b>	Please explain:
<b>Do you own any fitness equipment? Y or N</b>	Please explain:
<b>Do you have access to a health club already? Y or N</b>	Please explain:

### MEDICAL:

<b>Have you ever had any pain or injury to your ... (please explain in corresponding box)</b>	<b>Explain all YES answers below</b>
Head/Neck: <b>Y or N</b>	
Upper/Mid back: <b>Y or N</b>	
Hips/Low back: <b>Y or N</b>	
Knees: <b>Y or N</b>	
Ankles: <b>Y or N</b>	
Feet: <b>Y or N</b>	
Wrists/elbow/shoulder: <b>Y or N</b>	
<b>Have you ever had a concussion? Y or N</b> If yes, when and what grade?	
<b>Have you ever had any surgeries? Y or N</b> If yes, what body region and list year of the surgery.	
<b>Has a medical doctor ever diagnosed you with a chronic disease such as Coronary Heart Disease (CHD), Coronary Artery Disease (CAD), Hypertension (high blood pressure), High Cholesterol, Diabetes (Type I, II), Asthma, Epilepsy, hypo/hyperthyroid, etc...? Y or N</b>	
<b>Have you been diagnosed with Osteoporosis, Arthritis, Osteoarthritis, etc. Y or N</b>	Please explain:
<b>Have you ever had kidney problems, bladder incontinence, frequent urinary tract infections? Y or N</b>	Please explain:
<b>Have you had or do you experience gastro-intestinal pain?</b>	Please explain:
<b>Have you been diagnosed with any gastro-intestinal disorders?</b>	Please explain:
<b>Have you ever been diagnosed with depression? Y or N</b> If yes, have you been treated?	Please explain:
<b>Have you ever been diagnosed with an eating disorder? If yes, have you been treated? How long ago?</b>	Please explain:

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Are you currently taking medication and or/ dietary supplements? Y or N Please list your medications or provide a copy of a list.	Please explain:
Are you currently smoking or using smokeless tobacco? If no, how long ago did you quit? Y or N	Please explain:
Family medical history:	Please explain:
Date of your last physical, which MD?	Please explain:
Can you provide a medical release by doctor for participation in this program if requested? Y or N	
<b>PERSONAL:</b>	
Do you become discouraged when you exercise?	
How many times per week are you willing to work out on your own?	
Are you willing to modify your diet and current eating habits in order to achieve improved health and to meet your training goals?	
Are you willing to perform flexibility or workout routines at home?	
How many times per week are you willing to workout on your own?	
What physical activities do you enjoy the most?	
Weight History:	
<b>PREGNANCY HISTORY (Females only):</b>	
Are you currently pregnant? If so how far along?	
How many pregnancies and live births have you had? Please list the type of delivery.	
History of any complications during all pregnancies and/or labor? Clarify most recent:	
<b>POSTPARTUM HISTORY (Females only):</b>	
What was your pre-pregnancy weight and age during your first pregnancy?	
How much weight did you gain with each pregnancy?	

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Check the goals that you wish to obtain**:		
Physical appearance goals	Lifestyle goals	Training/Performance goals
<input type="checkbox"/> Weight management (gain/loss) <input type="checkbox"/> Prevent unwanted weight gain during postpartum year <input type="checkbox"/> Improved muscle mass/tone <input type="checkbox"/> Decreased body fat/improved body composition <input type="checkbox"/> Other	<input type="checkbox"/> Improved self esteem <input type="checkbox"/> Decreased alcohol consumption <input type="checkbox"/> Decreased depression <input type="checkbox"/> Decreased tobacco use <input type="checkbox"/> Decreased caffeine use <input type="checkbox"/> Decreased stress <input type="checkbox"/> Other	<input type="checkbox"/> Increased energy <input type="checkbox"/> Increased endurance <input type="checkbox"/> Increased power/strength <input type="checkbox"/> Increased vertical <input type="checkbox"/> Improved rapid response time <input type="checkbox"/> Other

*\*\*We will discuss your weekly/monthly goals individually*

NUTRITION:				
<b>How often do you eat fast food/restaurants?</b>	1Xday	2-3Xday	1Xweek	2-3Xweek
	1Xmth	2-3Xmth	4-6Xmth	
	Other, please explain:			
<b>Please list your favorite foods.</b>				
<b>Please list foods you dislike the most.</b>				
<b>Please list all foods consumed in the past 24 hours, including fluids consumed:</b>				
<b>How often do you eat a meal at home with family?</b>	1Xday	2-3Xday	1Xweek	2-3Xweek
	1Xmth	2-3Xmth	4-6Xmth	
	Other, please explain:			
<b>Who usually prepares your family meals?</b>	Please explain:			
<b>Do you have experience with cooking (food preparation)? Y or N</b> If yes, please list most common used method. (frying, grilling, baking, sautéing, boiling/poaching, etc.)	Please explain:			
<b>Do you have any food allergies/intolerances? Y or N</b>	Please explain:			
<b>Do you have any foods you avoid due to personal/religious beliefs? Y or N</b> If yes, which foods?	Please explain:			
<b>What dietary habit would you like to change the most?</b>	Please explain:			

### Responsibilities of Client:

I acknowledge that all medical information provided is accurate. I understand that withholding any information may have a negative effect on myself as well as my results. I accept the responsibility of informing my coaches if there is any change in my medical status during the course of this program.

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

Participant Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent Signature/Consent \_\_\_\_\_ Date \_\_\_\_\_

*(If participant is under 18 years of age)*