Physical Health and Fitness Levels

General Health

Do you have any chronic health conditions (e.g., diabetes, hypertension, heart disease)?

Are you currently taking any medications? If yes, please list them.

How would you rate your overall health? (Poor, Fair, Good, Very Good, Excellent)

How often do you visit your healthcare provider for check-ups? (Annually, Biannually, Rarely, Never)

Fitness Levels

How many days per week do you engage in physical exercise? (0, 1-2, 3-4, 5-6, 7)

What types of physical activities do you participate in? (e.g., walking, running, swimming, weight training, yoga)

On average, how many minutes do you spend exercising per session?

Do you experience any pain or discomfort during or after exercise? If yes, please describe.

Physical Activity Intensity

How would you describe the intensity of your workouts? (Light, Moderate, Vigorous)

Do you perform any strength training exercises? (Yes, No)

Do you incorporate flexibility or stretching exercises into your routine? (Yes, No)

Dietary Habits

Daily Nutrition

How many meals do you eat per day? (1, 2, 3, 4, More than 4)

Do you have regular meal times? (Yes, No)

How often do you eat breakfast? (Always, Often, Sometimes, Rarely, Never)

Food Choices

How would you rate your diet? (Poor, Fair, Good, Very Good, Excellent)

How often do you consume fruits and vegetables? (Daily, Several times a week, Occasionally, Rarely, Never)

How often do you consume whole grains? (Daily, Several times a week, Occasionally, Rarely, Never)

How often do you consume processed or fast foods? (Daily, Several times a week, Occasionally, Rarely, Never)

Hydration

How much water do you drink per day? (Less than 1 liter, 1-2 liters, 2-3 liters, More than 3 liters)

Do you consume sugary beverages or sodas? (Yes, No)

How often do you drink alcohol? (Daily, Weekly, Monthly, Rarely, Never)

Stress Levels

Stress Assessment

How often do you feel stressed? (Always, Often, Sometimes, Rarely, Never)

What are the primary sources of your stress? (e.g., work, family, finances, health)

How do you typically respond to stress? (e.g., anxious, angry, sad, overwhelmed)

Stress Management Techniques

What methods do you use to manage stress? (e.g., exercise, meditation, hobbies, socializing)

How effective are these methods for you? (Not effective, Somewhat effective, Effective, Very effective, Extremely effective)

How often do you practice relaxation techniques (e.g., meditation, deep breathing)? (Daily, Several times a week, Occasionally, Rarely, Never)

Lifestyle Habits

Sleep

How many hours of sleep do you get per night on average? (Less than 5, 5-6, 6-7, 7-8, More than 8)

Do you have a regular sleep schedule? (Yes, No)

How would you rate the quality of your sleep? (Poor, Fair, Good, Very Good, Excellent)

Smoking and Substance Use

Do you smoke or use tobacco products? (Yes, No)

Do you use recreational drugs? (Yes, No)

How often do you consume caffeine? (Daily, Several times a week, Occasionally, Rarely, Never)

Summary and Goals

Current Health and Fitness Concerns

What are your primary health concerns or conditions you are currently managing?

What are your main fitness goals? (e.g., weight loss, muscle gain, improved endurance)

Dietary and Stress Management Goals

What dietary changes are you hoping to make?

What stress management techniques are you interested in exploring or improving?

Support and Resources

What type of support or resources do you need to achieve your health and fitness goals? (e.g., coaching, nutritional guidance, stress management tools)