# Lifestyle Enhancement Request Form

**DATA PRIVACY**: You are being asked to provide data about yourself that is classified as private. The data will be used determine whether Minnetonka will require physician approval before you begin an exercise program, and to assist in determining what programs or activities will be recommended to you. You are not required to supply the data that has been requested, but if you refuse to provide the information, you may not be allowed to participate in programs or activities. Depending upon the nature of the information provided, Minnetonka may require physical approval before allowing you to participate in a program or activity. The information that you provide will be shared with city employees or contracting parties whose job duties require access, with the city's insurance carrier in the event of injury, and with those persons who you consent to have access.

Date:_____ Name:_____ ID: _____

Phone:_____ Email Address:_____

Are you a member of Williston Fitness Center or The Marsh? ❒ Yes ❒ No

Are you a City of Minnetonka employee? ❒ Yes ❒ No

What **Lifestyle Enhancement** service would you like to sign up for (circle)?

Personal Training Wellness Coaching Nutrition Consultation Fitness Assessment

Have you ever had any Minnetonka Lifestyle Enhancement services before? ❒ Yes ❒ No
If yes, whom did you work with? _____

Do you prefer a male or female trainer? ❒ Male ❒ Female ❒ Either

Specific trainer requested? List name _____

What are your fitness goals (please be as specific as possible)? _____

_____

**Are you interested in Individual or Group Training?** ❒ Individual ❒ Group

**Personal Training sessions are 1 hour in length. Please choose which package you are interested in:** ❒ 1 Session ❒ 4 Sessions ❒ 8 Sessions ❒ 12 Sessions

**When are you available to train?** (Please check all that apply) – **Required**

| Sunday | Monday | Tuesday | Wednesday | Thursday | Friday | Saturday |
|---|---|---|---|---|---|---|
| ❒ 12pm - 2p | ❒ 6am - 8am | ❒ 6am - 8am | ❒ 6am - 8am | ❒ 6am - 8am | ❒ 6am - 8am | ❒ 9am - 10am |
| ❒ 2pm - 4pm | ❒ 8am - 10am | ❒ 8am - 10am | ❒ 8am - 10am | ❒ 8am - 10am | ❒ 8am - 10am | ❒ 10am - 12pm |
| ❒ 4pm - 6pm | ❒ 10am - 12pm | ❒ 10am - 12pm | ❒ 10am - 12pm | ❒ 10am - 12pm | ❒ 10am - 12pm | ❒ 12pm - 2pm |
| ❒ 6pm - 8pm | ❒ 12pm - 2pm | ❒ 12pm - 2pm | ❒ 12pm - 2pm | ❒ 12pm - 2pm | ❒ 12pm - 2pm | ❒ 2pm - 4pm |
| | ❒ 2pm - 4pm | ❒ 2pm - 4pm | ❒ 2pm - 4pm | ❒ 2pm - 4pm | ❒ 2pm - 4pm | ❒ 4pm - 6pm |
| | ❒ 4pm - 6pm | ❒ 4pm - 6pm | ❒ 4pm - 6pm | ❒ 4pm - 6pm | ❒ 4pm - 6pm | ❒ 6pm - 8pm |
| | ❒ 6pm - 8pm | ❒ 6pm - 8pm | ❒ 6pm - 8pm | ❒ 6pm - 8pm | ❒ 6pm - 8pm | ❒ 8pm - 10pm |
| | ❒ 8pm - 10pm | ❒ 8pm - 10pm | ❒ 8pm - 10pm | ❒ 8pm - 10pm | ❒ 8pm - 10pm | |

# Health History Questionnaire

Please respond to the following items as accurately as possible.
This information will be used by the evaluator to ensure a safe exercise environment.
All information will remain confidential unless further professional consultation seems warranted.

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**Home Address** _____ **Phone** _____

**City** _____ **State** _____ **Zip**_____ **Email** _____

**Work Address** _____ **Work Phone**_____

**City** _____ **State** _____ **Zip**_____ **Title**_____

**Date of Birth**_____/_____/_____ **Age** _____ **Sex** ❒ M ❒ F _____

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**Individual to be contacted in the event of an emergency** _____

**Relationship to you** _____ **Phone**_____

**Address**_____

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**Smoking Status**

❒ Never Smoked
❒ Smoke only on occasion
❒ Smoke up to 1 pk/day
❒ Smoke up to 2 pk/day
❒ Smoke pipe/cigar only
❒ Ex-Smoker (how long_____)

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**Personal Physician** _____ **Physician's Phone**_____

**Do you have medical alert identification?** ❒ Yes ❒ No *If yes, where is it located?* _____

_____

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**Please list all medications that you are currently taking.**

| *Name of Drug* | *Dosage/Frequency* | *Reason for Taking* |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

**Please indicate if you have had, or presently have, any of the following:**

- ❒ **Thyroid disorder**
- ❒ **Ankle swelling**
- ❒ **Epilepsy or seizures**
- ❒ **Diabetes**
- ❒ **Heart attack/heart disease**
- ❒ **Heart surgery**
- ❒ **Heart failure**
- ❒ **Heart murmur**
- ❒ **Heart valve disease**
- ❒ **Heart palpitations**
- ❒ **Chest pain**
- ❒ **Cancer**
- ❒ **Stroke**
- ❒ **Dizziness or fainting**
- ❒ **Unusual shortness of breath**
- ❒ **Chronic Bronchitis**
- ❒ **Emphysema**
- ❒ **Recent hospitalization**
- ❒ **Asthma**
- ❒ **Exercise-induced asthma**
- ❒ *Glucose intolerance*
- ❒ *Obesity*
- ❒ *High blood pressure*
- ❒ *High blood cholesterol*
- ❒ *High blood triglycerides*
- ❒ Phlebitis
- ❒ Hernia
- ❒ Back trouble
- ❒ Arthritis
- ❒ Osteoporosis
- ❒ Bone or joint problems
- ❒ Low blood pressure
- ❒ Hypoglycemia
- ❒ Hay fever/other allergies
- ❒ Emotional disorder
- ❒ Eating disorder
- ❒ Anemia
- ❒Other:_____

**Are you, or may you be pregnant?** ❒ Yes ❒ No

**Describe any surgery that you have had within the last two years** _____

_____

_____

**Have you ever sustained any injury or experienced any type of chronic pain which has been diagnosed as due to physical activity or sports participation?** ❒ Yes ❒ No

*If Yes, please explain*_____

_____

**Has your weight fluctuated more than a few pounds?** ❒ Yes ❒ No

*If Yes, please explain*_____

**How long has it been since your last physical examination?**

❒ Less than 1 year ❒ 1-2 years ❒ 2-3 years ❒ 3 or more years

**What is your current cholesterol level? (Leave blank if you're not sure)**

____Total ____LDL _____HDL ____Triglycerides

**How often would you characterize your stress level as being high?**

❒ Occasionally ❒ Frequently ❒ Constantly

**Have any members of your immediate family been diagnosed with the following:**

| | Mother | Father | Sisters | Brothers | Grandparents |
|---|---|---|---|---|---|
| Heart disease | _____ | _____ | _____ | _____ | _____ |
| Heart attack (under age 50) | _____ | _____ | _____ | _____ | _____ |
| Heart surgery | _____ | _____ | _____ | _____ | _____ |
| Stroke (under age 50) | _____ | _____ | _____ | _____ | _____ |
| Diabetes | _____ | _____ | _____ | _____ | _____ |
| Pulmonary disease | _____ | _____ | _____ | _____ | _____ |
| Sudden death | _____ | _____ | _____ | _____ | _____ |
| High blood pressure | _____ | _____ | _____ | _____ | _____ |
| High cholesterol | _____ | _____ | _____ | _____ | _____ |
| Obesity | _____ | _____ | _____ | _____ | _____ |
| Other:_____ | _____ | _____ | _____ | | |

I hereby state that all of the above information is accurate to the best of my knowledge.

Signature _____ Date _____

## Exercise Status

**Do you currently workout on a regular basis?** ❒ Yes ❒ No

**Is your occupation?** ❒ Inactive (e.g., desk job) ❒ Light work (e.g., housework, light carpentry) ❒ Heavy work (e.g., heavy carpentry, lifting)

**How often do you perform cardiovascular exercise for at least 20-30 minutes per session?**
❒ No regular program ❒ 1 time/week ❒ 2 times/week ❒ 3-4 times/week ❒ 5 + times/week

**How often do you weight train?**
❒ No regular program ❒ 1 time/week ❒ 2 times/week ❒ 3-4 times/week ❒ 5 + times/week

**Please indicate which weight lifting equipment you use:** ❒ Free Weights ❒ Circuit Machines ❒ Body Weights

❒ **Starting Weight?**_____lbs **How many sets per muscle group?** ❒ 1-3 ❒ 4-6 ❒ 7+

**How many repetitions?** ❒ 4-6 ❒ 6-10 ❒ 8-12 ❒ 12-15 ❒ 15-20 ❒ >20

**Which muscle groups are emphasized?**
❒ Upper Back ❒ Lower Back ❒ Abdominals ❒ Chest ❒ Biceps ❒ Triceps
❒ Shoulders ❒ Hamstrings ❒ Calves ❒ Quads ❒ Other_____

**Briefly describe your exercise program** _____

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## Fitness Goals

**Please indicate your *top three* fitness goals.**

_____Improve strength
_____Improve muscle tone & shape
_____Improve cardiovascular fitness
_____Improve flexibility
_____Lose weight/decrease body fat
_____Gain weight
_____Improve diet/eating habits
_____Improve health
_____Reduce cholesterol
_____Reduce blood pressure
_____Increase energy
_____Reduce stress
_____Prevent injury
_____Rehabilitate injury
_____Train for a sports-specific event
_____Other_____

## Exercise Preferences

**How much time are you willing to devote to an exercise program?**_____Min/Session _____Days/Week

**On what days of the week would you like to exercise?** S M T W Th F S

**Mark the activities that you enjoy participating in or would like to try (choose up to 5).**

❒ Aerobics
❒ Active gardening
❒ Backpacking
❒ Baseball/softball
❒ Bicycling
❒ Cross country skiing
❒ Dancing
❒ Downhill skiing
❒ Football
❒ Golfing
❒ Hiking
❒ Hockey
❒ Jogging/running
❒ Martial arts
❒ Mountain climbing
❒ Racquetball/handball
❒ Rollerblading
❒ Rope skipping
❒ Rowing
❒ Skating
❒ Soccer
❒ Stair/bench stepping
❒ Stretching
❒ Swimming
❒ Tennis
❒ Volleyball
❒ Walking
❒ Weight training
❒ Yoga
❒ Other_____

# Nutrition Lifestyle

1. **What is your current weight?**_____lb _____kg **height?**_____ft. ____in.

2. **What would you like to weigh?**_____lb _____kg

3. **What is the most you ever weighed as an adult?**_____lb _____kg

4. **What is the least you ever weighed as an adult?**_____lb _____kg

5. **What weight loss methods have you tried?** _____

6. **Which do you eat regularly?**

❒ Breakfast ❒ Midmorning snack ❒ Lunch
❒ Midafternoon snack ❒ Dinner ❒ After-dinner snack

7. **How often do you eat out each week?** _____times

8. **What size portions do you normally have?**

❒ Small ❒ Moderate ❒ Large ❒ Extra large ❒ Uncertain

9. **How often do you eat more than one serving?**

❒ Always ❒ Usually ❒ Sometimes ❒ Never

10. **How long does it usually take you to eat a meal?** _____minutes

11. **Do you eat while doing other activities** (e.g., watching TV, reading, and working)**?** _____

12. **When you snack, how many times a week do you eat the following?**

| | | |
|---|---|---|
| _____Cookies, cake, pie | ____Candy | _____Diet soda |
| _____Soft drinks | _____Doughnuts | _____Fruit |
| _____Milk or milk beverage | _____Potato chips, pretzels, etc. | _____Peanuts or other nuts |
| _____Ice cream | _____Cheese and crackers | ____Other_____ |

13. **How often do you eat dessert?** _____times a day _____times a week

14. **What dessert do you eat most often?** _____

15. **How often do you eat fried foods?** _____ times a week

16. **Do you salt your food at the table?** ❒ Yes ❒ No

❒ Before tasting it ❒ After tasting it