

Hot Flash Huddle Client Health Fitness Questionnaire

Name: _____

Address: _____

Cell Phone: _____

Preferred Email: _____

Weight: _____

Protein in Grams Needed Daily: _____

Date of Birth:

Age:

Time Zone PST MST CST EST

In a few words, what is your overall WHY?

Why is it important that you reach this now?

Describe what you currently do for exercise?

Resistance Training	
Cardio	
Recovery	

Describe a typical day of nutrition (Food, Beverage)

Morning	
Afternoon	
Evening	

Rate the effectiveness of your current fitness program on a scale 1 is lowest 5 is highest.

1 2 3 4 5

Rate your current stress level on a scale 1 is lowest 5 is highest.

1 2 3 4 5

Rate your current sleep quality on a scale 1 is good, uninterrupted sleep, and 5 is interrupted sleep, trouble falling asleep, or staying asleep.

1 2 3 4 5

Rate your current perception of your personal daily eating habits from very healthy to not healthy on a scale, 1 is good 5 is not as good.

1 2 3 4 5

Rate your current exercise efficacy from liking to not liking exercise on a scale 1 is like it, 5 is not like it.

1 2 3 4 5

Which of the following do you need to achieve your goals?

- Accountability*
- Structure*
- Rewards*
- Extrinsic Goals*
- Intrinsic Goals*
- Variety in Training*
- A Workout Partner*
- Individualized Programming*

Have you had any of the following that might interfere with your fitness program?

- ***Surgeries***

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- ***Illness***

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- ***Chronic Conditions***

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How long have you been in perimenopause? (Last period 12-months previous with no break-through bleeding)

Do you get HRT, or other hormonal support or treatment/s?

Do you take medication? For which condition/s?

Do you have any injuries, restrictions, or limitations I should know about?

Do you take any supplements?

Which ones?



BODY METRICS

Measurement	Date Before	Date After	Changes
Body Fat%			
Lean Mass %			
Right Arm (in)			
Waist (in)			
Hips (in)			
Right Thigh (in)			
Right Calf (in)			
NOTES			

