



# Health and Fitness Assessment Questionnaire (Vitality)

## SECTION 1. DEMOGRAPHICS

**1.1 Details:** Please print in capital letters using black ink and tick the relevant box(es).

First name  Age  Gender  M -  F Male - Female

Surname

ID Number  Title  Birth Date  DD /  MM /  YYYY

Medical Aid  Medical aid membership number

Work number (  ) -  -  Home number (  ) -  -

Cell phone number (  ) -  -  Fax number (  ) -  -

Email  @

## SECTION 2. MEDICAL HISTORY

**2.1 Family History:** Do you have a family history (parents or siblings) of any of the following medical conditions?

Heart Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> Before or at the age of 50	High Cholesterol	<input type="checkbox"/> Yes	<input type="checkbox"/> Before or at the age of 50
Insulin Dependant Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> Before or at the age of 50	High Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> Before or at the age of 50
Non Insulin Dependant Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> Before or at the age of 50	Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> Before or at the age of 50
Peripheral Vascular Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> Before or at the age of 50	Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> Before or at the age of 50

Type:

**2.2. Personal Medical History:** Have you suffered, or do you suffer from any of these medical conditions?

High Cholesterol	<input type="checkbox"/> Yes	Heart Disease	<input type="checkbox"/> Yes	Exercise Induced Asthma	<input type="checkbox"/> Yes
Insulin Dependant Diabetes	<input type="checkbox"/> Yes	Non Insulin Dependant Diabetes	<input type="checkbox"/> Yes	Asthma	<input type="checkbox"/> Yes
High Blood Pressure	<input type="checkbox"/> Yes	Peripheral Vascular Disease	<input type="checkbox"/> Yes	Stroke	<input type="checkbox"/> Yes
Cancer	<input type="checkbox"/> Yes	Type:	<input type="text"/>		

**Diagnosed by?**  cardiologist  specialist physician  medical practitioner  blood test

**Diagnosed when?**  in the past year  1 - 5 years ago  > 5 years ago

**Specific Intervention?**  healthy dietary habits  medication  regular activity

**2.3. Medication**

Are you currently on medication for heart disease, peripheral vascular disease, cholesterol and/or blood pressure?  Yes  No

If yes, please write your **medical condition, name of medication and dosages**, below:

Condition: eg. Cholesterol	Medication: eg. Lipitor	Dosage: eg.10mg 1 / day
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>

**2.4. Preclusions**

**Present Symptoms:** Do you suffer from any of these medical conditions?

Chest pains while exercising	<input type="checkbox"/> Yes <input type="checkbox"/> No	Frequent fainting and/or dizzy spells	<input type="checkbox"/> Yes <input type="checkbox"/> No
Any flu-like symptoms (fever and/or muscle pains)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Palpitations	<input type="checkbox"/> Yes <input type="checkbox"/> No
Frequent wheezing /coughing	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shortness of breath at rest or with activity	<input type="checkbox"/> Yes <input type="checkbox"/> No
Ankle edema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Intermittent claudication	<input type="checkbox"/> Yes <input type="checkbox"/> No
Known heart murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No	Unusual fatigue with usual activities	<input type="checkbox"/> Yes <input type="checkbox"/> No

**Physical Injury:** Do you currently suffer from any physical ailment that would preclude you from performing this assessment?

Neuromuscular Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ligament	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bone	<input type="checkbox"/> Yes <input type="checkbox"/> No	Muscle	<input type="checkbox"/> Yes <input type="checkbox"/> No
Joint	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other	<input type="checkbox"/> Yes <input type="checkbox"/> No

**Assessor's comment** (based on ACSM's risk factors for exercise testing)

In your professional opinion, is the member fit to continue with this assessment?  Yes  No

COMMENT:

**2.5. Pregnancy**

Are you currently pregnant?  Yes  No

If yes, how many months pregnant are you? (e.g. 5)  months

Do you have clearance from your gynaecologist to perform this assessment?  Yes  No



SECTION 3. HEALTH HABITS

3.1. Smoking Status: Please tick the appropriate box relating to your smoking

- Never smoked
How long have you been an ex-smoker?
Current smoker

For Smokers only: Please tick only one of the options that best describe your current smoking situation

- I have no intention of becoming tobacco free in the next 6 months.
I intend to become tobacco free in the next 6 months.
I am trying to become tobacco free, but I am not always successful.
Although I am currently using tobacco again, in the past I have been tobacco free for more than 3 months.

Non Smoking

I confirm that I am a non-smoker and that:

- 1. I do not smoke and have not smoked any tobacco products, regularly or occasionally, within the last 3 months.
2. I agree to inform my insurers within 3 months of commencing smoking.
3. I agree to undergo an u-cotinine test to prove my non-smoker status should my insurer request one.

Please sign here to accept this declaration.

3.2. Alcohol Use: Please make the appropriate selection relating to your weekly alcohol consumption.

- I don't have any alcoholic drinks
Never more than 1 - 2 drinks per occasion or per day.
3 - 4 drinks in a day, only 2 - 3 per month.
3 - 4 drinks in a day, 4 times per month
3 or more drinks in a day, more than once a week and / or more than 4 drinks at a time.

3.3. Sleep: Please make the appropriate selection relating to your sleeping pattern.

- Undisturbed sleep
Disturbed sleeping pattern, 1-2 nights per week
Disturbed sleeping pattern, 3-4 nights per week
Disturbed sleeping pattern, 5-7 nights per week
In general, I wake up:
Refreshed
Unrefreshed

3.4 Stress Management:

Are you coping with your daily stress?

- No, and I have no intention to implement coping strategies in the next 6 months.
No, but I intend to learn how to cope with my daily stress in the next 6 months.
I am trying to cope but I do not always cope successfully.
Yes, I have been coping with my daily stress, but for LESS than 6 months.
Yes, I have been coping with my daily stress for MORE than 6 months.
Although I am not coping well with my daily stress, in the past I have coped well for more than 3 months.

3.5 Dietary Assessment

Think about your eating habits over the past year or so. Approximately how often do you eat each of the following foods? Tick one box for each food.

Table with 6 columns: Meat/Snack, Never/Once or less than once per month, 2-3 times per month, 1-2 times per week, 3-4 times per week, 5+times per week. Rows include Hamburgers, Red meat, Fried chicken, Hot dogs, Cold meats, Salad dressing, Margarine, Eggs, Bacon, Cheese, Full-cream milk, Potato chips, Potato crisps, Ice cream, Doughnuts.



**Fruit/Vegetables/Fibre**

	Never/Less than once per week	about once per week	2-3 times per week	4-6 times per week	Every day
Brown rice / wholewheat pasta	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fruit (not counting juice)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Green salad	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Potatoes with skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dried beans,e.g baked beans, Kidney beans, legumes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other vegetables	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High-fibre/bran cereal or high-fibre porridge or oat porridge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wholewheat, brown or high-fibre bread (e.g. rye)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Do you currently feel that you are following a healthy diet?**

- No, and I have no intention of following a healthy diet in the next 6 months.
- No, but I intend to follow a healthy diet in the next 6 months.
- I am trying to follow a healthy diet, but I am not always successful.
- Yes, I have been following a healthy diet, but for LESS than 6 months.
- Yes, I have been following a healthy diet for MORE than 6 months.
- Although I am currently following a less healthy diet, in the past I have followed a healthy diet for more than 3 months.

**SECTION 4. PHYSICAL ACTIVITY ASSESSMENT**

**4.1. Current Physical Activity Levels:** Please tick the most appropriate description of your current level of physical fitness.

- Poor
- Fair
- Acceptable
- Good
- Excellent

**4.2. Work and/or daily activities:** Please tick the box that best describes your activities in the working day {e.g. office and home based} - not your leisure time physical activity.

- I sit down and do not walk about much.
- I mostly walk and also lift heavy loads or climb stairs.
- I walk about a lot, but do not carry heavy loads.
- I do heavy manual work and physically strain myself.

**4.3. Physical Activity Status:** A typical exercise session consists of 20-30 minutes of exercise.

Over the past three months I would describe myself as having been:

- Inactive ( please go straight to 4.4 )
- Occasionally active - "at least 1-4 sessions per month"
- Somewhat active - "at least 1-2 sessions per week"
- Reasonably active - "at least 2-3 sessions per week"
- Active - "at least 3-4 sessions per week"
- Very active - "more than 4 sessions per week"

Over the past three months, the duration of my exercise sessions and/or recreational activity has ranged between a **minimum** of, and a **maximum** of:

(Minimum) Column A	(Maximum) Column B	On average, my total exercise time for the week is:	On average, I would describe the intensity of these sessions as:
<input type="checkbox"/> 0-15 minutes	<input type="checkbox"/> 0-15 minutes	<input type="checkbox"/> <60 minutes per week	<input type="checkbox"/> Very light (seated activity)
<input type="checkbox"/> 15-30 minutes	<input type="checkbox"/> 15-30 minutes	<input type="checkbox"/> 60-90 minutes per week	<input type="checkbox"/> Light (eg: housework)
<input type="checkbox"/> 30-60 minutes	<input type="checkbox"/> 30-60 minutes	<input type="checkbox"/> 90-120 minutes per week	<input type="checkbox"/> Light sweat
<input type="checkbox"/> 1-2 hours	<input type="checkbox"/> 1-2 hours	<input type="checkbox"/> 2-3 hours per week	<input type="checkbox"/> Sweating
<input type="checkbox"/> >2 hours	<input type="checkbox"/> >2 hours	<input type="checkbox"/> 3-4 hours per week	<input type="checkbox"/> Vigorous
		<input type="checkbox"/> >4 hours per week	

**4.4.** Please tick only one of the six options that best describe your current situation or what you intend to do regarding physical activity in the future.

**Are you moderately physically active?**

- No, and I have no intention of becoming moderately physically active in the next 6 months.
- No, but I intend to become moderately physically active in the next 6 months.
- I am trying to become moderately active, but my exercise routine is irregular.
- Yes, I have been moderately physically active, but for LESS than 6 months.
- Yes, I have been moderately physically active for MORE than 6 months.
- Although I am currently inactive, in the past I have been physically active for more than 3 months.

**SECTION 5. EXERCISE PROGRAMME**

**5.1. Please select ONE 12 week exercise programme**

**A. Lose Weight**

- \*General Cardio + toning
- Lose weight & run 21 km
- Lose weight & walk 5-10km
- Lose weight & cycle 40-60km
- Lose weight & walk 10-15km
- Lose weight & cycle 80-120km
- Lose weight & run 5-10km

**B. Gain Weight (muscle)**

**C. \*Stay Healthy**

**D. \*Look after health condition**

**E. \*Become generally fitter**

**F. \*Get bootcamp fit**

**G. \*Get my body back in shape**

**H. Improve my fitness for walking:**

- 5km
- 10km
- 15km
- 21km

**I. Improve my fitness for running:**

- 5km
- 10km
- 21km
- 42km

**J. Improve my fitness for cycling:**

- 40km
- 60km
- 80km
- 100km
- 120km
- 200km

**K. Improve my fitness for swimming:**

- 600m
- 1000m
- 1600m

**L. Improve my fitness for triathlon:**

- Sprint triathlon
- Standard triathlon

**\* Would you prefer to exercise in a gym or home environment?**

- Gym
- Home

Note: the sports specific plans are outdoor-specific

