FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

YMCA OF AUBURN-LEWISTON
62 Turner Street
Auburn, ME 04210
P: 207-795-4095
F: 207-795-4058
www.alymca.org

Initial Assessment Questionnaire

Name:_______________________________________ Date:_____________

DOB:___________Gender:_________

Email:_____________________________________Phone:_______________

How do you prefer me to contact you?

- ○ Email
- ○ Phone
- ○ Text
- ○ Other (please specify):

Emergency Contact Name:____

Emergency Contact Phone Number:____

In general, what are your goals? Check all that apply.

- ○ Lose weight/fat
- ○ Gain weight
- ○ Maintain weight
- ○ Add muscle
- ○ Improve physical fitness
- ○ Feel better
- ○ Have more energy
- ○ Get control of eating habits
- ○ Improve athletic performance

Please list all of your concerns about your health, eating habits, fitness, or body.

____
____
____
____
____
____
____
____

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Out of all of the above concerns, which ones feel most important/urgent?

1.____
2.____
3.____

Please explain why?

____
____
____
____
____

What do you expect from me as your coach?

____
____
____

Have you tried anything in the past to change your habits, your health, your eating, and/or your body? If so, what?

____
____
____

Which of those things worked will for you? (Even if you might not be doing it right now.)

____
____
____

Which of those things did not work well for you?

____
____
____

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How, specifically, would you like your habits, your health, your eating, and /or your body to be different?

____

____

____

Have you already made changes to your habits, your health, your eating, and/or your body recently? If so, what?

____

____

____

Until now, what has blocked or held you back from changing?

____

____

____

Right now, how would you rank your overall eating/nutrition habits?

Horrible 1 2 3 4 5 6 7 8 9 10 Awesome!!

Why?

____

____

How would you rate your daily activity level?

- ○ Sedentary: Little or no exercise and a desk job
- ○ Lightly Active: Light exercise 1 to 3 days per week
- ○ Moderately Active: Moderate exercise 3 to 5 days per week
- ○ Very Active: Heavy exercise 6 to 7 days per week
- ○ Extremely Active: Very heavy exercise or a physical job or training twice per day

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Who lives with you/ is part of your support system?

- Spouse or partner
- Roommate
- Child(ren)
- Pet(s)
- Grandchildren
- Other

Do you have children? If yes, how many and what are their ages?

____

____

Who does most of the grocery shopping in your household? Check all that apply

- Me
- Spouse or partner
- Roommate
- Child(ren)
- Other family (e.g. parent, grandparent, sibling, etc.)

Who does most of the cooking in your household? Check all that apply

- Me
- Spouse or partner
- Roommate
- Child(ren)
- Other family

Who decides on most of the menu/meal types in your household? Check all that apply

- Me
- Spouse or partner
- Roommate
- Child(ren)
- Other family

Right now, how much do the people and things around you support health, fitness, and/or behavior change?

Not at all 1 2 3 4 5 6 7 8 9 10 Completely

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Have you been diagnosed (currently or in the past) with any significant medical condition(s) and or injuries? Y N

If yes, please explain:

____

____

Right now, do you have any specific health concerns such as illness, pain, and/or injuries? Y N

If yes, please explain:

____

____

Right now, are you taking any medications, either over-the- counter or prescription? Y N

If yes, please explain:

____

____

Do you have any food allergies or intolerances? Y N

If yes, please explain:

____

____

Please list any foods you do not eat:

____

____

____

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Think about all of the activities you are involved in (e.g. work, school, caregiving, housework, travel…) Then assess as best as you can:

Given all of the demands in your life, what is your typical stress level on an average day?

No Stress 1 2 3 4 5 6 7 8 9 10 Extreme

How do you feel about your schedule, time use, and overall business?

Life is insane/packed 1 2 3 4 5 6 7 8 9 10 Life is calm/relaxed

On average, how many hours per night do you sleep?

- 4 or fewer hours
- 5 hours
- 6 hours
- 7 hours
- 8 hours
- 9 hours
- 10+ hours

How do you normally cope with stress?

____
____
____

How **READY** are you to change your behaviors and habits?

Not at all 1 2 3 4 5 6 7 8 9 10 Completely

How **WILLING** are you to change your behaviors and habits?

Not at all 1 2 3 4 5 6 7 8 9 10 Completely

How **ABLE** are you to change your behavior and habits?

Not at all 1 2 3 4 5 6 7 8 9 10 Completely

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Goals:

Please list your long term goals:

____
____
____
____

List three obstacles from reaching your long term goal (e.g., describe situations that make it harder to change).

1. ____
2. ____
3. ____

List three strategies you will use to overcome these obstacles.

1.____
____

2.____
____

3.____
____

List three short-term goals and a target date to help you make your long-term goal more attainable.

1. ____
____
2. ____
____
3. ____
____

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