HEALTH / MEDICAL QUESTIONNAIRE

Date: ____________________________ Date of Birth: ____________________________
Name: ____
Age: __________________ Height: __________________ Weight: __________________
Phone: (H) ___________________ (W) ___________________ (C) __________________
Fax: ____________________________ Email: ____________________________________

In case of emergency, whom may we contact?
Name: ____
Relationship: _________________________ Phone: ________________________________
Name: ____
Relationship: _________________________ Phone: ________________________________

Who is your main physician?
Name: ____ Phone: _____________________

Past / Present Conditions: Have you had **or** do you presently have any these conditions. (*Check if Yes*)

Heart Attack	( )	Stroke	( )	Ulcer	( )
Chest Pains	( )	Hypertension	( )	Cancer	( )
Heart Murmur	( )	Seizures	( )	Arthritis	( )
Fainting	( )	High Cholesterol	( )	Osteoporosis	( )
Palpitations	( )	Diabetes	( )	Postural (spine)	( )
Ankle Edema	( )	Lung Disease	( )	Other	( )

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Have you ever experienced discomfort, shortness of breath and/or chest pain with moderate exercise?
No ( ) Yes ( )

Do you experience severe dizziness, limb numbness or leg cramping with exertion?
No ( ) Yes ( )

Family History: Circle the relative (blood related) who died of a heart attack before age 55 (male) / age 65 (female).
Father *Mother* *Brother* *Sister* *Grandmother* *Grandfather*

Any other medical conditions (past/present) within your family?
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Fitness / Activity History:

Profession: ____

Retired: No ( ) Yes ( )

Numbers of hours worked per week: <20 20-44 41-60 >60

More than 25% of time spent on job: (circle all that apply)

Sitting at desk *Lifting or carrying loads* *Standing* *Walking* *Driving*

Do you exercise regularly? No ( ) Yes ( )

How long has it been since you exercised regularly? ______________________________

What kind of exercising do you presently do?____________________________________

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How many days per week do you accumulate 30 minutes of moderate activity?

0 1 2 3 4 5 6 7

Do you have experience with resistance machines and/or free weights?

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What type of cardiovascular exercise are you familiar with?

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Exercise Restrictions:

Do you have pain or restricted range of motion in any of the following areas (involving for example, joints, bones, ligaments, tendons, bursae, etc.)? Please include any old injuries and surgeries. Check all that apply.

Neck	( )	Back/upper	( )	Pelvis/Hips	( )
Shoulders	( )	/mid	( )	Knees	( )
Elbows	( )	/lower	( )	Ankles	( )
Wrists	( )			Feet	( )

Do you have any exercise restrictions due to physical or medical reasons?

No ( ) Yes ( ) If yes, please explain.____

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Have these problems been diagnosed by a physician? No ( ) Yes ( )

If yes, please explain. ____

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What exercise was contraindicated or recommended?______________________________

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Name of physician/physical therapist/chiropractor:________________________________