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	( )

_____
_____
_____
_____
_____

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?
_____
_____
_____

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?_____
_____
_____

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?
_____

What type of cardiovascular exercise are you familiar with?
_____

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._____
_____
_____
_____

Have these problems been diagnosed by a physician? No ( ) Yes ( )
If yes, please explain. _____
_____

What exercise was contraindicated or recommended?_____
_____
_____

Name of physician/physical therapist/chiropractor:_____