

Health History Questionnaire

Name _____ Date _____

Street address _____ City _____

Phone (home) _____ (work) _____

Email address _____ (cell phone number) _____

Person to contact in case of emergency: _____ Date of birth _____

Name _____ Phone _____

For most people, physical activity should not pose any problem or hazard. The following questions are designed to identify the small number of adults for whom physical activity might be inappropriate or those who should have medical advice concerning the type of activity most suitable for them.

Common sense is your best guide in answering these questions. Please read them carefully and check the "Yes" or "No" response opposite the question if it applies to you.

Yes No

___ ___ 1. Has your doctor ever said you have heart trouble? If yes, please describe the problem and state when it was diagnosed.

___ ___ 2. Do you frequently have pain in your heart or chest?

___ ___ 3. Do you often feel faint or have spells of severe dizziness?

___ ___ 4. Has a doctor ever told you that your blood pressure was too high?

___ ___ 5. Has your doctor ever told you that you have a bone or joint problem, such as arthritis, that has been aggravated by exercise or might be made worse by exercise?

___ ___ 6. Is there a good physical reason not mentioned here why you should not follow an activity program even if you wanted to do so?

___ ___ 7. Are you over age 65 and/or not accustomed to vigorous exercise?

___ ___ 8. Are you or have you ever been a diabetic?

___ ___ 9. Are you now pregnant, or have you been pregnant within the last 3 months?

___ ___ 10. Have you had any surgery in the last 3 months?

___ ___ 11. Have you been hospitalized in the last 2 years? If so, when and why?

___ ___ 12. Have you ever seen a chiropractor, acupuncturist, or other alternative medicine practitioner? If so, when and why?

Please check the box if you have ever experienced any of the following symptoms:

	When first experienced	Treatment used
<input type="checkbox"/> Pain or discomfort in the chest	_____	_____
<input type="checkbox"/> Unaccustomed shortness of breath	_____	_____
<input type="checkbox"/> Dizziness	_____	_____
<input type="checkbox"/> Labored or uncomfortable breathing, with or without pain	_____	_____
<input type="checkbox"/> Swollen ankles	_____	_____
<input type="checkbox"/> Heart palpitations	_____	_____
<input type="checkbox"/> Heart murmur	_____	_____
<input type="checkbox"/> Limping	_____	_____

Yes No Do you have high blood pressure? If yes, what is your current blood pressure without medication?

Yes No Are you taking any medication for hypertension? If so, what medication?

Yes No Is your total serum cholesterol level over 240?

Yes No Do you smoke?

Yes No Have you ever smoked? If so, when did you quit?

Yes No Do you have diabetes?

Yes No Do you have a family member who has had coronary or atherosclerotic disease before age 55?

Yes No Do you have pain or discomfort in your back?

Yes No Do you have pain or discomfort in your knee? If so, right or left?

Yes No Do you have pain or discomfort in your shoulder? If so, right or left?

Yes No Do you have pain or discomfort in your elbow? If so, right or left?

Yes No Do you have pain or discomfort in your wrist? If so, right or left?

Yes No Do you have pain or discomfort in your ankle? If so, right or left?

If you checked "Yes" above, please describe your pain. On a scale of 1 to 10, with 1 being almost nonexistent and 10 being excruciating, how severe is it? Does it get more or less severe as the day goes on? When do you notice it? What really aggravates it?

Yes No Have you ever torn ligaments or cartilage in your knee? If so, when? _____
Did you have surgery on this knee? If so, when? _____

Yes No Have you ever dislocated your shoulder? If so, when?

Yes No Have you ever had shoulder surgery? If so, which shoulder? When?

Yes No Have you ever had a neck injury, such as whiplash? If so, when?

Yes No Have you ever been treated for a spinal disk injury? If so, when?

Yes No Do you ever experience tingling or numbness in your elbows or hands?

What is the present state of your general health? _____

What regular physical activities do you do now? _____

How often? _____ For how long each session? _____

I, _____, certify that I understand the foregoing questions and my answers are true and complete. I also understand that this information is being provided as part of my initial consultation and may not be periodically updated.

I, _____, assume the risk for any changes in my medical condition that might affect my ability to exercise.

Signature

Date

If you answered yes to one or more questions and you have not recently consulted with your doctor, do so before beginning an exercise program. Tell your doctor which questions you answered yes to and explain that you plan to undergo an exercise program that may include, but may not be limited to, weight and/or resistance training. After medical evaluation, ask your doctor

1. which activities you may safely participate in, and
2. what specific restrictions, if any, should apply to your condition and which activities and/or exercises you should avoid.

I, _____, acknowledge that I have read the foregoing statements and understand the content thereof.

Signature

Date