Health Screening Questionnaire

Today's date:_____

Name: _____ _____ Birth date: _____ Phone: (Home) _____

Email: _____ Phone: (Cell) _____

Occupation:_____

Person to contact in case of emergency: _____Tel:_____

Physician's Name: _____Tel: _____

Medical History

Please indicate if any of these statements apply to you by placing YES in the space provided

1. History of heart problem (i.e. Chest pain, heart murmur, or stroke) _____
2. Diabetes Mellitus _____
3. Asthma, breathing, or lung problems _____
4. Seizures, seizure medication, neurological problems, dizziness _____
5. High blood pressure _____
6. Back problems, joint or muscle disorder still affecting you _____
7. Recent surgery (last 12 months) _____
8. Any medications_____
9. Do you have joint problems that might be aggravated by exercise? ____

Skeletal Injuries

Back_____

Neck_____

Knee(R, L) _____

Shoulder(R, L) _____

Other injuries: _____

Goals

1. What are your fitness goals? (For example, overall better fitness, weight loss, strength, power, muscular endurance, cardio fitness, flexibility, agility, core stability or balance)

_____

_____

2. What areas do you want to concentrate on or emphasize? (i.e. specific areas to strengthen,

joint stability, cardio or core conditioning, balance)

_____

_____

Fitness History

3. How long has it been since you have exercised regularly? (2 or more times/week).

_____

4. If you are an experienced exerciser or athlete, what exactly is your current

program?_____

5. Are there any exercises that are contraindicated or not recommended by your physician or

physical therapist?_____

6. How would you describe your level of daily activities? Please check one.

Light (office work)__ Moderate(Manual labor)__ Heavy (construction)__

7. What is your available time and frequency for exercise?

What days: M T W TH F

What times: AM_____ PM_____

8. Any special considerations or requests?

_____

9. What kind of music do you like? _____