Health History Questionnaire

Name _____ Date _____

Street Address _____

City, State, Zip Code _____

Phone (home) _____ (work) _____

Date of Birth _____ Age _____ Weight _____ Goal Weight _____

Person to contact in case of emergency:

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" opposite the question if it applies to you.

Yes **No**

❑ yes ❑ no 1. Has your doctor ever said you have heart trouble? If yes, please describe the problem and state when it was diagnosed.

_____

_____

❑ yes ❑ no 2. Do you frequently have pains in your heart and chest?

❑ yes ❑ no 3. Do you often feel faint or have spells of severe dizziness?

❑ yes ❑ no 4. Has a doctor ever told you that your blood pressure was too high?

❑ yes ❑ no 5. Has your doctor ever told you that you have a bone or joint problem, such as arthritis, that has been aggravated by or might be made worse by exercise?

❑ yes ❑ no 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?

❑ yes ❑ no 7. Are you over age 55 and/or not accustomed to vigorous exercise?

❑ yes ❑ no 8. Are you or have you ever been a diabetic?

❑ yes ❑ no 9. Are you now or have you been pregnant within the last 3 months?

❑ yes ❑ no 10. Have you had any surgery in the last three months?

❑ yes ❑ no 11. Have you been hospitalized in the last two years? If so, when and why?

❑ yes ❑ no 12. Have you ever seen a chiropractor, acupuncturist, or other alternative medicine provider? If so, when and why?

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

	When first experienced	**Treatment used**
❑ Pain or discomfort in the chest		
❑ Unaccustomed shortness of breath		
❑ Dizziness		
❑ Labored or uncomfortable breathing		
❑ Swollen ankles		
❑ Heart palpitations		
❑ Heart murmur		
❑ 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, which one?

❑ yes ❑ no Is you total serum cholesterol over 240?

❑ yes ❑ no Do you smoke?

❑ yes ❑ no Have you ever smoked? If so, when did you quit? _____

❑ yes ❑ no Do you have a family member who has had coronary or atherosclerotic disease prior to 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 progresses? When do you notice it? What aggravates it?

_____

_____

_____

_____

❑ yes ❑ no Have you ever torn ligaments or cartilage in your knee?

If so when? _____

❑ yes ❑ no 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, right or left?

If so, 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 disc 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 done so, consult with your doctor before beginning any 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 not be limited to, weight and/or resistance training and cardiovascular 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
