



health medical questionnaire page 1

name _____ date _____

address- _____

phone (day)- _____ (evening)- _____

sex- _____ -- height- _____ -- weight- _____ date of birth _____ - -age- _____

occupation _____

personal physician - _____

address - _____

phone (day)- _____ date of last physical exam- _____

Do you have your physician's consent to participate in an exercise program _____

Were you referred? _____ if yes, by whom? _____

Are you currently taking any prescriptions or medications- _____ - -

please list- _____

Medical History

Have you had or do you have any of the following:

___-heart attack	___-abnormal blood lipids/ cholesterol	___-anemia
___-coronary angioplasty	___-lightheadedness or fainting with exercise	___-asthma
___-cardiac surgery	___-heart murmur	___-family history
___-chest discomfort during or after exercise	___-rapid heart beats or palpitations	___-thyroid condition
___-high/low blood pressure	___-diabetes	___-cancer
___-shortness of breath with exercise		___-other _____



health medical questionnaire page 2

Have you ever had or do you currently have any of the following conditions:

Neck

- | | | |
|---|---|--|
| <input type="checkbox"/> -Pinched nerve | <input type="checkbox"/> -Fractures | <input type="checkbox"/> -Sprains/Strains |
| <input type="checkbox"/> -Surgery | <input type="checkbox"/> -Disc problems | <input type="checkbox"/> -Unexplained pain |
| <input type="checkbox"/> -Tight musculature | <input type="checkbox"/> -Other _____ | |

Spine/Back

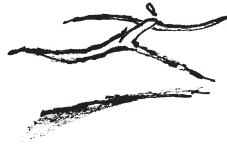
- | | | |
|--|---|---|
| <input type="checkbox"/> -Fracture | <input type="checkbox"/> -Muscle spasm | <input type="checkbox"/> -Scoliosis |
| <input type="checkbox"/> -Surgery | <input type="checkbox"/> -Pain with lifting | <input type="checkbox"/> -Ruptured/Herniated disc |
| <input type="checkbox"/> -S-I joint pain | <input type="checkbox"/> -Osteoporosis | <input type="checkbox"/> -Chronic low back pain |
| <input type="checkbox"/> -Arthritis | <input type="checkbox"/> -Stiffness | <input type="checkbox"/> -Spondylogenic problems |
| <input type="checkbox"/> -Congenital deformity | <input type="checkbox"/> -Other _____ | |

Pelvis/Hip

- | | | |
|--------------------------------------|--|---|
| <input type="checkbox"/> -Fracture | <input type="checkbox"/> -Groin strain | <input type="checkbox"/> -Subluxation/Dislocation |
| <input type="checkbox"/> -Tendinitis | <input type="checkbox"/> -Surgery | <input type="checkbox"/> -Contusion/Hip pointer |
| <input type="checkbox"/> -Bursitis | <input type="checkbox"/> -Leg length discrepancy | |
| <input type="checkbox"/> -Other | _____ | |

Thigh

- | | | |
|---|---|--|
| <input type="checkbox"/> -Fracture | <input type="checkbox"/> -Quadriceps strain | <input type="checkbox"/> -Hamstring strain |
| <input type="checkbox"/> -Surgery | <input type="checkbox"/> -Ruptured muscle | <input type="checkbox"/> -Calcium deposits |
| <input type="checkbox"/> -Tight I.T. band | <input type="checkbox"/> -Tendinitis | |
| <input type="checkbox"/> -Other | _____ | |



health medical questionnaire page 3

Knee/Lower Leg

- | | | |
|---|---|--|
| <input type="checkbox"/> -Fracture | <input type="checkbox"/> -Ligament damage | <input type="checkbox"/> -Strain/Sprain |
| <input type="checkbox"/> -Patella-femoral pain | <input type="checkbox"/> -Surgery | <input type="checkbox"/> -Subluxation/Dislocation |
| <input type="checkbox"/> -Tendinitis | <input type="checkbox"/> -Shin splints | <input type="checkbox"/> -Cartilage damage/removal |
| <input type="checkbox"/> -Limited Range of Motion | <input type="checkbox"/> -Other _____ | |

Ankle/Foot

- | | | |
|---|---|---|
| <input type="checkbox"/> -Fracture | <input type="checkbox"/> -Ligament damage | <input type="checkbox"/> -Compartment Syndrome |
| <input type="checkbox"/> -Orthotics | <input type="checkbox"/> -Surgery | <input type="checkbox"/> -Tendinitis |
| <input type="checkbox"/> -Strain/Sprain | <input type="checkbox"/> -Subluxation/Dislocation | <input type="checkbox"/> -Limited Range of Motion |
| <input type="checkbox"/> -Other _____ | | |

Shoulder/Clavicle

- | | | | |
|---|---|-------------------------------------|--------------------------------------|
| <input type="checkbox"/> -Fracture | <input type="checkbox"/> -Separation | <input type="checkbox"/> -Arthritis | <input type="checkbox"/> -Tendinitis |
| <input type="checkbox"/> -Subluxation/Dislocation | <input type="checkbox"/> -Degenerative rotator cuff disease | | |
| <input type="checkbox"/> -Limited range of motion | <input type="checkbox"/> -Other _____ | | |

Arm

- | | | |
|---------------------------------------|--|---|
| <input type="checkbox"/> -Fracture | <input type="checkbox"/> -Calcium Deposits | <input type="checkbox"/> -Ruptured Muscle |
| <input type="checkbox"/> -Other _____ | | |

Elbow

- | | | |
|---------------------------------------|---|---|
| <input type="checkbox"/> -Fracture | <input type="checkbox"/> -Sprain/Strain | <input type="checkbox"/> -Subluxation/Dislocation |
| <input type="checkbox"/> -Tendinitis | <input type="checkbox"/> -Surgery | <input type="checkbox"/> -Limited range of motion |
| <input type="checkbox"/> -Other _____ | | |

Hand, Wrist, Fingers

- | | | |
|---------------------------------------|---|---|
| <input type="checkbox"/> -Fracture | <input type="checkbox"/> -Sprain/Strain | <input type="checkbox"/> -Surgery |
| <input type="checkbox"/> -Arthritis | <input type="checkbox"/> -Carpal Tunnel | <input type="checkbox"/> -Limited range of motion |
| <input type="checkbox"/> -Other _____ | | |



health medical questionnaire page 4

Are you presently receiving or have you received physical therapy-_____

if yes, with whom and when: _____

Are there any other comments you would like to give concerning your health?

exercise history and personal goals

Are you presently involved in a regular exercise program-_____

if yes, please list activity, duration, frequency and intensity

How much time are you able to devote to an exercise program:---

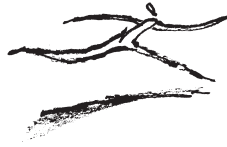
days/week-_____---time-_____

What type of physical activities do you like:

What do you want your exercise program to do for you:

- | | | |
|--|--|---|
| <input type="checkbox"/> -increase muscular strength | <input type="checkbox"/> -improve cardiovascular fitness | <input type="checkbox"/> -injury prevention |
| <input type="checkbox"/> -post-rehab conditioning | <input type="checkbox"/> -improve sports performance | <input type="checkbox"/> -reduce health risks |
| <input type="checkbox"/> -improve flexibility/mobility | <input type="checkbox"/> -reshape and tone body | <input type="checkbox"/> -increase energy level |
| <input type="checkbox"/> -stop smoking/drinking | <input type="checkbox"/> -reduce stress level | <input type="checkbox"/> -body fat weight loss |
| <input type="checkbox"/> -weight gain | <input type="checkbox"/> -improve eating habits | |
| <input type="checkbox"/> -other (list)-_____ | | |

What can I do for you?



health medical questionnaire page 5

lifestyle and nutrition

Do you currently smoke-_____--(if yes, how often) _____

Have you quit smoking--_____--(if yes, when) _____

Do you use alcohol-_____--(if yes, how much and how often)-_____

Do you drink coffee or soda with caffeine-_____--(if yes, how much & how often)-_____

Are you presently on a diet-_____

Do you consider yourself- ___-overweight ___-about right ___-underweight

How many meals a day do you usually eat-_____ -

How would you describe your nutritional habits:- good fair poor

How would you describe your knowledge of nutrition: good fair poor

Is your job active or sedentary.- Do you experience a lot of stress in your life-_____

Describe your knowledge of exercise and fitness:- good fair poor

How physically fit do you think you are-_____

physical assessment

resting blood pressure-_____ resting pulse-_____ THR range-_____

body composition:-female:

skin fold: triceps- _____
suprailium- _____
thigh- _____
total- _____
% body fat _____

male:

chest- _____
abdomen- _____
thigh- _____
total- _____
% body fat _____

girth measurements (right side of body)

upper arm- _____
chest- _____
waist- _____

hips- _____
thigh- _____
calf- _____

Muscular strength/endurance

Sit and reach- _____ Push-ups- _____ Chin-ups- _____ Crunches- _____