

Client Data Questionnaire

This information will help us to track your progress with our facility. Please answer each of these questions as accurately as you can. Should you have any questions, feel free to ask. Your responses will be treated in a confidential manner.

Today's Date: ____ / ____ / ____ Your Name: _____

Facility ID: _____

Sex: Male Female (Circle one)

Date of Birth: ____ / ____ / ____

Address: _____

City: _____

Zip: _____ State: _____

Home Phone: _____

Email Address: _____ Day Ph: _____ Mobile: _____

Emergency Contact: _____ Phone: _____

Doctor: _____ Phone: _____

Medical/Health Status Questionnaire

On this questionnaire, a number of questions regarding your physical health are to be answered. Please answer every question as accurately as possible so that a correct assessment can be made. Please place a check in the space to the left of the question to answer "Yes." Leave blank if your answer is "No." Please ask if you have any questions. Your responses will be treated in a confidential manner.

Today's Date: ____ / ____ / ____ Your Name: _____

Medical Screening

- Do you have any personal history of heart disease (coronary or atherosclerotic disease)?
 - Any personal history of diabetes or other metabolic disease (thyroid,renal,liver)?
 - Any personal history of pulmonary disease, asthma, interstitial lung disease or cystic fibrosis?
 - Have you experienced pain or discomfort in your chest apparently due to blood flow deficiency?
 - Any unaccustomed shortness of breath (perhaps during light exercise)?
 - Have you had any problems with dizziness or fainting?
 - Do you have difficulty breathing while standing or sudden breathing problems at night?
 - Have you experienced a rapid throbbing or fluttering of the heart?
 - Do you suffer from ankle edema (swelling of the ankles)?
 - Have you experienced severe pain in leg muscles during walking?
 - Do you have a known heart murmur?
 - Has your serum cholesterol been measured at greater than 200 mg/dl?
 - Are you a cigarette smoker?
 - Has your HDL (the "good" cholesterol) been measured at greater than 60 mg/dl?
 - Would you characterise your lifestyle as "sedentary"?
 - Have you had a high fasting blood glucose level on 2 or more occasions (≥ 110 mg/dl)?
 - Are you 20% or more overweight or have you been told your "BMI" was greater than 30?
 - Have you been assessed as hypertensive on at least 2 occasions (systolic > 140 mmHg or diastolic > 90 mmHg)?
 - Do you have any family history of cardiac or pulmonary disease prior to age 55?
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Medical History - Detail

Are you currently being treated for high blood pressure?

If you know your average blood pressure, please enter: _____ / _____

Please check all conditions or diagnoses that apply:

- | | | |
|--|---|---|
| <input type="checkbox"/> Abnormal EKG? | <input type="checkbox"/> Limited Range of Motion? | <input type="checkbox"/> Stroke? |
| <input type="checkbox"/> Abnormal Chest X-Ray? | <input type="checkbox"/> Arthritis? | <input type="checkbox"/> Do You Suffer from Epilepsy or Seizures? |
| <input type="checkbox"/> Rheumatic Fever? | <input type="checkbox"/> Bursitis? | <input type="checkbox"/> Chronic Headaches or Migraines? |
| <input type="checkbox"/> Low Blood Pressure? | <input type="checkbox"/> Swollen or Painful Joints? | <input type="checkbox"/> Persistent Fatigue? |
| <input type="checkbox"/> Asthma? | <input type="checkbox"/> Foot Problems? | <input type="checkbox"/> Stomach Problems? |
| <input type="checkbox"/> Bronchitis? | <input type="checkbox"/> Knee Problems? | <input type="checkbox"/> Hernia? |
| <input type="checkbox"/> Emphysema? | <input type="checkbox"/> Back Problems? | <input type="checkbox"/> Anemia? |
| <input type="checkbox"/> Other Lung Problems? | <input type="checkbox"/> Shoulder Problems? | <input type="checkbox"/> Are You Pregnant? |
| | <input type="checkbox"/> Recently Broken Bones? | |

Has a doctor imposed any activity restrictions? If so, please describe:

Family History

Have your mother, father, or siblings suffered from (please select all that apply):

- | | |
|--|---|
| <input type="checkbox"/> Heart attack or surgery prior to age 55. | <input type="checkbox"/> High cholesterol |
| <input type="checkbox"/> Stroke prior to age 50. | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Congenital heart disease or left ventricular hypertrophy. | <input type="checkbox"/> Obesity |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Leukemia or cancer prior to age 60. | <input type="checkbox"/> Osteoporosis |

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Medications

Please Select Any Medications You Are Currently Using:

<input type="checkbox"/> Diuretics	<input type="checkbox"/> Other Cardiovascular
<input type="checkbox"/> Beta Blockers	<input type="checkbox"/> NSAIDS/Anti-inflammatories (Motrin, Advil)
<input type="checkbox"/> Vasodilators	<input type="checkbox"/> Cholesterol
<input type="checkbox"/> Alpha Blockers	<input type="checkbox"/> Diabetes/Insulin
<input type="checkbox"/> Calcium Channel Blockers	<input type="checkbox"/> Other Drugs (record below).

Please list the specific medications that you currently take:

Lifestyle

Are you a cigarette smoker? If so, how many per day? _____

Previously a cigarette smoker? If so, when did you quit? _____

How many years have you smoked or did you smoke before quitting? _____

Do you/did you smoke (Circle one): Cigarettes Cigars Pipe

Please Rate Your Daily Stress Levels (select one):

- Low Moderate High but I enjoy the challenge High: sometimes difficult to handle High: often difficult to handle.

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Alcohol Units Table

Do you drink alcoholic beverages?

How many units of alcohol do you
consume per week: _____

(see Alcohol Units Chart)

Dietary Habits. Please Select All That Apply.

- | | |
|--|--|
| <input type="checkbox"/> I seldom consume red or high-fat meats. | <input type="checkbox"/> I eat at least 5 servings of fruits/vegetables per day. |
| <input type="checkbox"/> I pursue a low-fat diet. | <input type="checkbox"/> I almost always eat a full, healthy breakfast. |
| <input type="checkbox"/> My diet includes many high-fiber foods. | <input type="checkbox"/> I rarely eat high-sugar or high-fat desserts. |

Other

Please Indicate Any Other Medical Conditions or Activity Restrictions That You May Have. It is important that this information be as accurate and complete as possible

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- Is any of this information critical to understanding your readiness for exercise? Are there any other restrictions on activity that we should know about?

Thank you for taking the time to complete this questionnaire!