



The Fitness Docs

Preliminary Questionnaire (Please Print)

Name _____ Date _____

Address _____ City _____ State _____ Zip _____

Phone (Home) _____ (Work/Cell) _____

E-Mail _____

Date of Birth _____ Age _____ Gender: Male Female

Occupation _____

Dominant posture during work—Circle appropriate answer(s):

Sitting Standing Lifting Heavy Physical Labor Bending

Emergency Contact _____ Phone _____

Primary Care Physician (PCP) _____

Phone _____ Fax (if known) _____

Health Status **BOX 1 (Risk Factors are in Red)**

Do you currently have any of the following health conditions? [Please circle YES or NO]

YES / NO High Cholesterol (total cholesterol greater than 200 ml/dL or HDL less than 40 mg/dL)?
(or if LDL is greater than 130 mg/dl)

YES / NO Hypertension (blood pressure greater than 140/90)? Confirmed by 2 separate occasions.

YES / NO Do you currently smoke?

YES / NO Have you been diagnosed with Diabetes Mellitus?

YES / NO Has a family member (sibling/parent) experienced a heart attack prior to age 50?

YES / NO Are you obese (defined by a BODY MASS INDEX [or BMI] of 30 or greater)*

YES / NO Do you lead a sedentary lifestyle? (Defined as no planned exercise)

Do you have any of the following conditions? [Specify YES or NO beside each condition]

_____ Heart Disease, Heart Attack, Angina

_____ Coronary Angioplasty/Cardiac Surgery

_____ Rapid Heartbeats/Palpitations

_____ Heart Murmur or Unusual Cardiac Findings

_____ Peripheral Vascular Disease

_____ Stroke

_____ Kidney Disease

_____ Thyroid or Metabolic Disorder

_____ Chest Discomfort/Pain, During Rest/Exercise

_____ Unusual Fatigue or SOB at Rest/ Exercise

_____ Ankle Swelling

_____ Lymphedema

Respiratory Problems : _____ Asthma _____ Chronic Bronchitis _____ Emphysema or COPD

*This is a simple test that your instructor can determine for you.

BOX 2

Do you have a history of any of the following?

- YES / NO** Orthopedic Problems (Joint/Bone/Muscular)
 Please Specify _____
- YES / NO** Chronic Back Problems
 Please Specify _____
- YES / NO** Neurological Impairments (i.e., Multiple Sclerosis, Parkinson’s Disease, Ataxia, etc.)
 Please Specify _____
- YES / NO** **Women: Are you 50 years of age or older?**
- YES / NO** **Men: Are you 40 years of age or older?**
- YES / NO** Major Surgery/ Hospitalization (within the last year)
- YES / NO** Currently Pregnant?
- YES / NO** Cancer (Please specify): _____
- YES / NO** Do you have any medical condition(s) or physical limitation(s) that should be considered
 Prior to your participation in an exercise program? If yes, please explain:

List all Medication(s) you are taking:

YES / NO I have read and understand the questions asked. Any questions I may have had while completing this questionnaire were answered to my satisfaction. I verify that all the information noted above is accurate to my knowledge and I understand that it is my responsibility to update THE FITNESS DOCS of any changes in medical status.

PROGRAM PARTICIPATION AND GENERAL FITNESS CONSENT FORM

I have chosen to participate in a supervised program of physical fitness offered by THE FITNESS DOCS. I realize that as part of my program I may receive a postural screen (or a Functional Movement Screen™ or both). I realize that this does NOT constitute physical therapy and that I am not under the care of a physical therapist. I recognize the possibility of certain unusual changes during exercise. These changes include: Abnormal blood pressure, fainting, disorders of heartbeat, and instances of a heart attack. Every reasonable effort will be made to minimize these risks, and hereby acknowledge and accept these risks. To my knowledge, I do not have any limiting physical condition or physical or mental challenge that would preclude participation in a program at THE FITNESS DOCS.

Participant’s Signature _____ **Date** _____

Medical Clearance is recommended if client is a man over 45/women over 55 and/or possesses 2 or more risk factors at any age OR 1 or more major signs of CAD (angina, SOB at rest, ankle edema, tachycardia) or those with KNOWN CV disease, metabolic disease, or pulmonary disease. Ultimately, the Health Fitness Professional needs to practice good clinical judgment as all cases are NOT black and white.