



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           | _____                                       |  |



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**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- \_\_\_\_\_