

Performance Physical Therapy Fitness Center Health/Medical History Questionnaire

Name _____

Do you now or have you ever smoked? Yes No

If you previously smoked, how many years did you smoke? _____

How often did you smoke? _____

How long ago did you quit? _____

Do you consider yourself: (*check one*)

Sedentary Light exercise Moderately active Highly active

If active, what kind of exercise do you now do? _____

Would you characterize your life as: (*check one*)

Highly stressful Moderately stressful Low in stress

Medical History -- Please check the boxes next to any of the following conditions you now have, or have experienced in the past.

- | | | |
|---|--|--|
| <input type="checkbox"/> Heart attack, coronary bypass or other cardiac surgery | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Increased anxiety or depression |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Ankle swelling | <input type="checkbox"/> Emotional disorders |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Cold hands or feet | <input type="checkbox"/> Fatigue, lack of energy |
| <input type="checkbox"/> Peripheral vascular disease | <input type="checkbox"/> Unusual shortness of breath | <input type="checkbox"/> Difficulty sleeping |
| <input type="checkbox"/> Phlebitis, emboli | <input type="checkbox"/> Lightheadedness or fainting | <input type="checkbox"/> Migraine or recurring headache |
| <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Epilepsy, seizures | <input type="checkbox"/> Swollen, stiff, or painful joints |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Anemia | <input type="checkbox"/> Hernia |
| <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Chest discomfort | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Bursitis |
| <input type="checkbox"/> Extra, skipped or rapid heart beats/palpitations | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Low back pain |
| | <input type="checkbox"/> Chronic, recurring cough | <input type="checkbox"/> Other (<i>list</i>) _____ |

Please explain any boxes you checked: _____

Please list any prescribed medications you are now taking: _____

Please list any over the counter medications or dietary supplements you are now taking:

Please list any illness, hospitalization or surgical procedure within the past two years:

Please give date of last physical examination and results: _____

Family History

Have any of your blood relatives had any of the following? *(Please check those that apply. Include grandparents, parents, aunts, uncles and siblings. Please list relative and age the incident occurred.)*

	Relation to you:	At what age?
<input type="checkbox"/> Heart attack	_____	_____
<input type="checkbox"/> Stroke	_____	_____
<input type="checkbox"/> Coronary disease	_____	_____
<input type="checkbox"/> Congenital heart disease	_____	_____
<input type="checkbox"/> High blood pressure	_____	_____
<input type="checkbox"/> Diabetes	_____	_____
<input type="checkbox"/> Coronary operations	_____	_____
<input type="checkbox"/> Elevated cholesterol	_____	_____

Fitness Goals

Please check / describe specific goals and rate their importance.

- | | | |
|---|--|--|
| <input type="checkbox"/> Improve strength | <input type="checkbox"/> Increase energy | <input type="checkbox"/> Improve flexibility |
| <input type="checkbox"/> Improve cardiovascular fitness | <input type="checkbox"/> Improve muscle shape / size | <input type="checkbox"/> Lose body weight / fat |
| <input type="checkbox"/> Gain weight / muscle | <input type="checkbox"/> Rehabilitate injury | <input type="checkbox"/> Injury prevention |
| <input type="checkbox"/> Improve diet / eating habits | <input type="checkbox"/> Reduce stress | <input type="checkbox"/> Stop smoking / drinking |
| <input type="checkbox"/> Additional goals (list): _____ | | |
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WAIVER AND ACKNOWLEDGEMENT

IN CONSIDERATION for the right to enter and remain on the premises of PERFORMANCE PHYSICAL THERAPY and FITNESS for observation, exercise, therapy, or other use, the undersigned agrees as follows:

1. I acknowledge that I have been advised to seek the medical advice of a physician prior to engaging in any program of exercise.
2. I have examined any equipment prior to use and found it to be in good working order. If it is not in good working order, I will not use it.
3. I assume all risk of injury or death from exercise and will not hold Performance Physical Therapy and Fitness liable or otherwise responsible for my injury or death resulting from exercising or an exercise program. I waive any claim that I may have against Performance Physical Therapy and Fitness from my injury or death as a result of using the facilities, exercising, or remaining, on the premises.

IN WITNESS WHEREOF, the undersigned, having read and understood the above does hereby voluntarily set his or her hand.

SIGNATURE: _____ **DATED:** _____

