Client Health Status Questionnaire

PERSONAL AND EMERGENCY CONTACT INFORMATION

Name:____ Phone:____

Address: ____ Emergency Contact: ______________________________

City: ________________________ Zip Code: ___________ Emergency Phone: _______________________________

D.O.B.____ Personal Physician: ______________________________

Age: ________________________ Sex: M F Physician Phone: _________________________________

Weight: _____________________ Height: _____________

MEDICAL HISTORY

Please check the following conditions you have experienced.

______Heart attack

______Heart surgery

______Cardiac catheterization

______Coronary angioplasty (PTCA)

______Cardiac pacemaker

______Cardiac rhythm disturbance

______Heart valve disease

______Heart failure

______Heart transplantation

______Congenital heart disease

Symptoms

______You experience chest discomfort with exertion.

______You experience unreasonable shortness of breath at any time.

______You experience dizziness, fainting or blackouts.

______You take heart medications.

Other Health Issues

______ You have asthma or other lung disease (e.g., emphysema).

______You have burning or cramping sensations in your lower legs with little physical activity.

______You have concerns about the safety of exercise.

______You take prescription medications.

______You are pregnant.

ASSESSMENT

______ You are a man older than 45 years.

______You are a woman older than 55 years, have had a hysterectomy or are postmenopausal.

______You have diabetes (Type 1 or Type 2). Please circle which type.

______You smoke or you quit smoking within the previous six months.

______Your blood pressure is ≥ 130/80 mmHg.

______Your blood cholesterol is ≥ 200 mg/dL.

______You have a close male blood relative (father or brother) who had a heart attack or heart surgery before the age of 55 or a close female blood relative (mother or sister) who had a heart attack or heart surgery before the age of 65.

______You are physically inactive (you get < 30 minutes of physical activity on or at least three days per week).

______Your waist circumference is ≥40 in. (101.6 cm in men) or ≥ 35 in. (88.9 in women)

MEDICATIONS

Are you currently taking any medication? [ ] Yes [ ] No

If yes, please list all of your prescribed medications and how often you take them. ___________________________

____

____

Fitness

List the frequency, intensity (e.g., low, moderate or strenuous), duration and type of weekly exercise. __________

____

What are your specific goals for participating in an exercise program? _____________________________________

____

Please inform me of any changes that occur in your health.

If you have answered yes to any of the questions indicating that you have significant cardiac, pulmonary, metabolic or orthopedic conditions that may be exacerbated with exercise, you agree to permit me to contact your physician (with your prior knowledge) regarding your health status.

Signature:____ Date:________________

Trainer Signature:____ Date:________________

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AHA / ACSM stratification: [ ] Low [ ] Moderate [ ] High Physician consent required: [ ] Yes [ ] No