

Basic Fitness PT Health History Questionnaire

NAME: _____ DATE: _____
 HEIGHT: _____ WEIGHT: _____ BLOOD PRESSURE: _____ RHR: _____
 PHYSICIAN: _____
 Office phone number: _____

Heart History/Conditions

Please check all that apply: None Apply

<input type="checkbox"/>	Heart attack/ MI - if yes, how many?	<input type="checkbox"/>	Heart Surgery
<input type="checkbox"/>	Cardiac catheterization	<input type="checkbox"/>	Coronary angioplasty (PTCA)
<input type="checkbox"/>	Pacemaker/Implantable cardiac defibrillator (AICD)/rhythm disturbance	<input type="checkbox"/>	Heart valve disease
<input type="checkbox"/>	Heart failure	<input type="checkbox"/>	Heart transplant
<input type="checkbox"/>	Congenital heart disease	<input type="checkbox"/>	Heart murmur

Please explain any boxes you checked (include dates when applicable): _____

**If you said YES, to any of the above, a medical release form is required prior to any exercise. Physician information must be complete.

Cardiovascular Disease Risk Factors

Please mark the appropriate response:

Yes No

- — Do you smoke?
- — Are you a man older than 45 years?
- — Are you a woman older than 55 years, have had a hysterectomy or are post-menopausal?
- — Is your blood pressure > 140/90?
- — Is your cholesterol >240 mg/dL?
- — Do you have a close blood relative who has had a heart attack before the age of 55 (father/brother) or 65 (mother/sister)?
- — Are you physically inactive (e.g. exercise less than 30 minutes at least three times per week?)

**IF you answered YES, to 3 or more of the above questions, a medical release form is required prior to any exercise.

Note: *If you answered yes to any of the above questions, it is important that you seek the advice of your physician prior to starting a training program at Basic Fitness PT. In some instances, Basic Fitness PT may request a physician's clearance prior to beginning an exercise program. **Initial:** _____*

Current Health Conditions

Please check all that apply: None Apply

<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Pre or postnatal
<input type="checkbox"/>	Auto immune disease	<input type="checkbox"/>	Tingling, numbness, or radiating pain
<input type="checkbox"/>	Stroke	<input type="checkbox"/>	Chronic Fatigue
<input type="checkbox"/>	Epilepsy or seizures	<input type="checkbox"/>	Cancer
<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Migraine or recurring headaches
<input type="checkbox"/>	Allergies ** List	<input type="checkbox"/>	Other ** List
<input type="checkbox"/>	Hernia	<input type="checkbox"/>	

Please explain any "Yes" answers:

Physical Activity Readiness Questionnaire

Please mark the appropriate response:

Yes No

- ___ ___ Has a doctor ever told you that you have a heart condition and recommended only medically supervised exercise?
- ___ ___ Do you have chest pain brought on by physical activity?
- ___ ___ Have you developed chest pain in the past few months?
- ___ ___ Have you ever occasionally lost consciousness or fallen over as a result of dizziness?
- ___ ___ Has a doctor ever recommended medication for your blood pressure or a heart condition?
- ___ ___ Are you aware, through your own experience or a doctor's advice, of any other physical reason that would prohibit you from exercising without medical supervision.

Please explain any "Yes" answers:

Describe your activity level:

Activities of Daily Living Weekend Warrior Active Athletic Other: _____

Are you currently exercising? _____

How many days per week? _____

Duration of exercise sessions? _____

Types of activities involved? _____

Note: If you answered yes to any of the above questions, it is important that you seek the advice of your physician prior to starting a training program at Basic Fitness PT. In some instances, Basic Fitness PT may request a physician's clearance prior to beginning an exercise program. **Initial:** _____

Orthopedic Conditions

Please check all that apply: None Apply

<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	Multiple Scleroses
<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	Post-Polio
<input type="checkbox"/>	Joint pain or problems	<input type="checkbox"/>	Fractures or broken bones
<input type="checkbox"/>	Back and/or neck pain	<input type="checkbox"/>	Fibromyalgia
<input type="checkbox"/>	Tendon or Ligament repair	<input type="checkbox"/>	Other (please list)

Please explain any boxes you checked "Yes": include dates and joint(s) effected when applicable:

Yes No

— — Are you currently under the supervision of a Physical Therapist?

— — Are you currently under the supervision of any other Allied Health Professional?

If YES, please list name & contact phone number: _____

General Medical History

Please list all medications you are taking & for what purpose:

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

Please list date of last physical examination and results:

**** PLEASE NOTIFY BASIC FITNESS PT WITH ANY CHANGE IN HEALTH STATUS ****

Note: *If you answered yes to any of the above questions, it is important that you seek the advice of your physician prior to starting a training program at Basic Fitness PT. In some instances, Basic Fitness PT may request a physician's clearance prior to beginning an exercise program.* **Initial:** _____