GETCORE
functional exercise training

Health and Activity Questionnaire

Name: _____ Date of birth: _____

Address: _____ City: _____

State: _____ Zip Code: _____ Fax: _____

Phone (Home): _____ (Cell): _____

Email address: _____

Emergency contact: _____

Phone (Home): _____ (Cell): _____

Personal physician: _____

Phone: _____ Medical#: _____

Have you had or do you presently have any of the following? (Check if YES and describe below.)

_____ Recent operation

_____ Edema (swelling of ankles)

_____ High blood pressure/Low blood Pressure

_____ Musculoskeletal/Orthopedic injury

_____ Seizures

_____ Lung disease

_____ Heart attack or known heart disease

_____ Fainting or dizzine

_____ Diabetes

_____ High Cholesterol

_____ Shortness of breath at rest or with mild exertion

_____ Chest pains

_____ Asthma

_____ Exercise Induced Asthma

_____ Slow/Rapid heart rate

_____ Intermittent claudication (calf cramping)

_____ Pain, discomfort in the chest, neck, jaw, arms, or other areas

_____ Known heart murmur

_____ Unusual fatigue or shortness of breath with usual activities

_____ Temporary loss of visual acuity or speech, or short-term numbness or weakness in one side, arm, or leg of your body

_____ Cancer

_____ Stroke

_____ Are you pregnant?

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_____ Orthopnea (the need to sit up to breathe comfortably) or paroxysmal (sudden, unexpected attack) or nocturnal dyspnea (shortness of breath at night)

_____ Any known allergies? List: _____

_____ Other (please describe): _____

_____

Family History

Have any of your first-degree relatives (parent, sibling, or child) experienced the following conditions? (Check if yes.) In addition, please identify at what age the condition occurred.

_____ Heart attack

_____ Heart operation (Bypass surgery, Angioplasty, Coronary Stent placement)

_____ Congenital heart disease

_____ High blood pressure

_____ High cholesterol

_____ Diabetes

_____ other major illness: _____

Explain checked items:

_____

_____

Activity History

1. How would you rate your usual exercise activity?
Low _____ Moderate _____ High _____

Describe your exercise activities (please include type, frequency /week, and length of exercise session):

_____

_____

2. Do you have injuries that may interfere with exercising?
Yes _____No _____ If yes, briefly describe:

_____

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3. Do you smoke? Yes _____ No _____ If yes, how much per day and what was your age when you started?
Amount per day _____ Age _____

4. Body weight_____ Height _____

5. List the medications you are presently taking.

_____

_____

_____

6. What are your specific fitness/health goals? (Circle all that apply)

1. Increase strength and endurance
2. Improve flexibility/balance
3. Improve cardiovascular health
4. Improve muscle tone
5. Lose weight
6. Increase lean muscle mass
7. Cross training /Sport specific
8. Feel better overall
9. Other _____
_____

7. How did you hear about GET CORE Functional Exercise Training?

_____

I have read, understood, and completed this questionnaire. Any questions that I had were answered to my full satisfaction.

Signature_____

Name_____Date_____

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