The
PARKINSON
Center for Mobility

# Health-History / Physical Activity Questionnaire

Name: _____ Date: _____ Date of birth: _____
Address: _____
Phone number: _____ Emergency Contact/Phone _____

## Medical Information

1. How would you describe your present state of health?

Very healthy ____ Healthy ____ Unhealthy ____ Not sure: _____

2. List current medications, how often you take them, and dosages (include prescriptions and over-the-counter medications). _____

_____

3. Please check any that apply to you and list any important information about your condition:
   Allergies - Specify: _____

____ Amenorrhea
____ Anxiety
____ Asthma
____ Chronic sinus condition
____ Depression
____ Eating disorder(s)
____ High blood pressure
____ Heart disease
____ Hypo/hyperthyroidism
____ Intestinal problems
____ Menopausal symptoms
____ PMS
____Pregnant
____ Anemia
____ Arthritis
____ Celiac disease
____ Crohn's disease
____ Diabetes
____ Gastroesophageal reflux disease (GERD)
____ Low blood pressure
____ Hypoglycemia
____ Insomnia
____ Irritable bowel syndrome (IBS)
____ Osteoporosis
____ Polycystic ovary syndrome
____ Stomach Ulcer

Major surgeries: _____

Injuries within the last two years: _____

Describe any other health conditions that you have: _____

## **Medical Information** (continued)

5. Please check any that apply to you and list any important information about your condition:

| | Date of Diagnosis |
|---|---|
| ____ Parkinson's disease | _____ |
| ____ Stroke (affected side - Left Right) | _____ |
| ____ Traumatic brain injury | _____ |
| ____ Multiple Sclerosis | _____ |
| ____Orthopedic injury | _____ |

## **Please check any symptoms associated with your diagnosis:**

____ Paralysis
____ Weakness
____ Impaired balance and coordination
____ Muscle irregularities
____ Feeling unsteady or dizzy
____ Edema
____ Pins and needles on parts of the body
____ Lose feeling on part of the body
____ Fatigue
____ Pain
____ Stiffness
____ Tremors in the hands, arms, legs, jaw or head
____ Bladder problems
____ Constipation
____ Hallucinations
____ Brain fog
____ Slowed movements (bradykinesia)
____ Freezing when walking
____ Impaired posture
____ Loss of automatic movements
____ Depression
____ Cognitive impairment
____ Blood pressure changes

List any other challenges:_____

## Family History

1. Has anyone in your immediate family been diagnosed with the following?
   ____ Heart disease
   ____ High blood pressure
   ____ Cancer
   ____ Diabetes
   ____ Osteoporosis

## Substance-relate Habits (circle which apply)

1. Do you drink alcohol? Yes No
   If yes, how often? _____times per week. Average amount? _____

2. Do you drink caffeinate beverages? Yes No

3. Do you use tobacco? Yes No
   If yes, how much (cigarettes, cigars, or chewing tobacco per day)? _____

## Physical Activity

1. Do you currently participate in any structured physical activity? Yes. No.

   If so, please describe:

   _____ minutes of Cardiovascular activity, _____ times per week

   _____ resistance training sessions per week

   _____ flexibility-training sessions per week

   _____ Minutes of sports or recreational activities per week

   List sports or activities you participate in: _____

2. Do you engage in any other form of physical activity? Yes. No

   If yes describe: _____

3. Have you ever experienced any injuries that may limit your physical activity? Yes. No
   If yes, describe: _____
4. Do you have physical-activity restrictions? Yes. No

   If so, please list: _____

   _____

   _____

5. What are your honest feelings about exercise/physical activities? _____

   _____

6. What are some of your favorite physical activities? _____

   _____

## Occupational

1. Do you work? Yes. No

   If yes, what is your occupation? _____

   If you work, what is your work schedule? _____

   _____

   _____

2. Describe your activity level during the workday: _____

   _____

   _____

## Sleep and Stress

1. How many hours of sleep do you get at night? _____

2. Rate your average stress level from 1 (no stress) to 10 (constant stress) _____

3. What is most stressful to you? _____

4. How is your appetite affected by stress? Increased. Not affected. Decreased

## Weight History

1. What is your present weight? _____ Don't know

2. What would you like to do with your weight? Lose wt. Gain wt. Maintain wt.

3. What was your lowest weight within the past 5 years? _____

4. What was your highest weight in the past 5 years? _____

5. What do you consider to be ideal weight (the sustainable weight at which you feel best)? _____

   Don't know

## Goals

1. On a scale of 1 to 10. How likely to adopt a healthier lifestyle (1= very likely; 10 = very unlikely) ?

2. Do you have specific goals for improving your health? _____

   _____

   _____

   Do you have a weight loss goal? Yes No

   If yes, what is it? _____

1. Why do you want to lose weight? _____

   _____

2. Are there any specific areas of your body you want to strengthen?

   _____