Health Questionnaire

Client Name: _____ Date: _____

Date of Birth: _____ Phone# _____ Cell # _____

E-mail: _____

Address: _____

_____

All information is confidential and will not be shared!

Individual History

Common sense is your best guide in answering these questions. Please read the questions carefully and check YES or NO.

YES NO

1. Has your doctor ever said that you have a heart condition and that you should only do physical activity recommended by a doctor?
2. Do you feel pain in your chest when you do physical activity?
3. In the past month, have you had chest pain when you were not doing physical activity?
4. Do you lose your balance because of dizziness or do you ever lose consciousness?
5. Do you have a bone or joint problem that could be made worse by a change in your physical activity?
6. Is your doctor currently prescribing drugs (for example, water pills) for your blood pressure or heart condition?
7. Do you know of any other reason why you should not do physical activity?

If you answered Yes to one or more questions:

- ☐ Talk to your doctor by phone or in person BEFORE you start becoming much more physically active or BEFORE you have a fitness appraisal. Tell your doctor about the PAR-Q and which questions you answered YES.
- ☐ You may be able to do any activity you want-as long as you start slowly and build up gradually. Or, you may need to restrict your activities to those that are safe for you. Talk with your doctor about the kinds of activities you wish to participate in and follow his / her advice.
- ☐ Find our which community programs are safe and helpful for you.

If you answered No honestly to all PAR-Q questions, you can be reasonably sure that you can:

- ☐ Start becoming much more physically active - begin slowly and build gradually. This is the safest and easiest way to go.
- ☐ Take part in a fitness appraisal – this is an excellent way to determine your basic fitness so that you can plan the best way for you to live actively.

DELAY BECOMING MUCH MORE ACTIVE

- ☐ If you are not feeling well because of a temporary illness such as a cold of fever-wait until you feel better; or
- ☐ If you are or may be pregnant-talk to your doctor before you start becoming more active.

Please note: If your health changes so that you then answer YES to any of the above question, tell your fitness or health professional. Ask whether you should change your physical activity plan.

You are encouraged to copy the PAR-Q but only if you use the entire form.

NOTE: If the PAR-Q is being given to person before he or she participate in a physical activity program or a fitness appraisal, this section may be used for legal or administrative purposes.

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

Name_____

Signature_____

General Medical History

Please put a mark by all the ones that apply.

Heart History

_____ Heart Attack
_____ Heart Surgery
_____ Cardiac catheterization
_____ Coronary angioplasty (PTCA)
_____ Cardiac pacemaker
_____ Cardiac rhythm disturbance
_____ Heart valve disease
_____ Heart failure
_____ Heart transplant
_____ 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.

Additional Health Issues

_____ You have asthma or other lung disease (e.g., emphysema)
_____ You have burning or cramping sensations in your lower legs with minimal physical activity.
_____ You have joint problems (e.g. arthritis) that limit your physical activity.
_____ You have back pain.
_____ You take prescription medications.
_____ You are pregnant.

Risk Factor Assessment

_____ You are a man older than 45 yr.
_____ You are a woman older than 55 yr. have had a hysterectomy, or are postmenopausal.
_____ You have diabetes (type 1 or type 2).
_____ You smoke or you quit smoking within the previous 6 month.
_____ Your blood cholesterol is > 140/90 mmHg.
_____ Your cholesterol is > 200 mg. dl^{-1}
_____ 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 at least 3 days per week.
_____ Your waist circumference is > 40 in. (101.6 cm in men) or >35 in. (88.9 cm in women)

Medication

Are you currently taking any medication? _____Yes _____No
If yes, please list all of your prescribed medication and how often you take them, whether daily (D) or as needed (PRN)._____
_____

Of the medications you have listed, are there any you don not take as prescribed?
_____

Please inform the health professional immediately of any changes that occur in your health status.

Patient Information Release Form

If you have answered yes to questions indicating that you have significant cardiac, pulmonary, metabolic, or orthopedic problems that may be exacerbated with exercise, you agree it is permissible for us to contact your physician regarding your health status.

Signature: _____ Date: _____

Fitness Professional: _____ Date: _____

History: Past / Present

1. Please explain in detail what you would like to gain from your assessment-our time together, please be detailed as this is your time and I customize to your needs?
    a. What are your specific goals? Do you have a specific movement goal in mind?

    b. What goal is the most important to you (if there are multiple)?

2. Would you like to be educated on your body as assessment findings become uncovered during the assessment?

3. Have you EVER had surgery? This includes dental, cosmetic or any technique that is invasive?
    a. Please describe and date:

4. Are you experiencing any aches, pains, discomforts, stiff joints, soreness or stabbing pain at the moment?
    a. If yes, please describe in detail in addition mark the chart below to the best of your knowledge.

    b. What is your "chief" complaint?

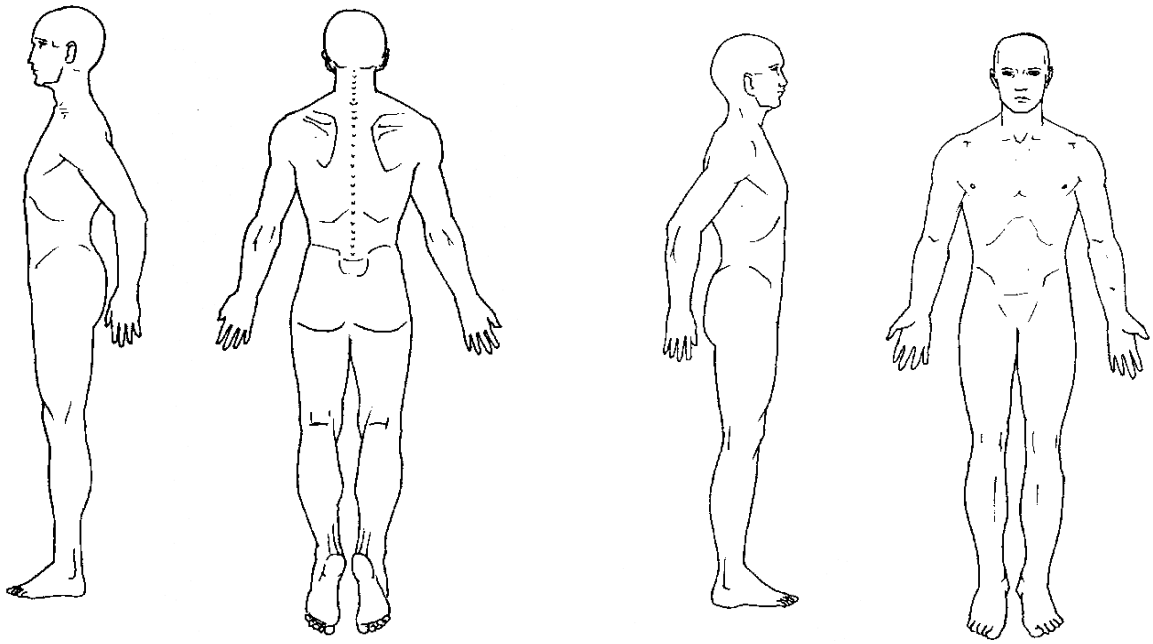
    c. How long have you had this chief complaint, when did you first notice?

    d. How does your chief complaint affect you on a day-to-day basis?

    e. Are symptoms brought on by certain positions or activities?

    f. What positions or motions alleviate your complaint?

    g. Is the discomfort worse in the AM / afternoon / PM or same?



Lifestyle Questionnaire

The following are very important questions regarding your current threshold to all forms of stress and will be used to start the evaluation process, please spend time answering thoroughly, thank you.

1. Your current MOVEMENT status:
    a. How much exercise do you get each week (walking, biking, running, lifting weights, yoga, Pilates, stretching, etc.)…
        i. What do you do?
        ii. For how long?
        iii. At what intensity (how hard)?
        iv. How many times do you do this?
    b. What sports (if any) or activities did you participate in as a child, teenager?
        i. Describe:
    c. Do you play any sports at the moment? Would you like to in the future, if yes, which ones?
        i. Describe:

2. Do you make time for rest / recovery before, during or after exercise? If so, how often and how much time do you spend on recovery?
    a. Describe:

3. Have you EVER or CURRENTLY feel discomfort or pain when moving?
    a. If yes, please describe the movement(s) and what it feels like in your own words:

4. Do you avoid certain activities / exercises because of pain?
    a. If yes, please describe:
5. What other activities outside of your conditioning program will you be participating in?

6. What is your occupation and what type of movement (if at all) is involved?

7. How much time do you spend in a seated position?

8. Have you ever had the following (please circle): Physical therapy, Chiropractic, Massage, Acupuncture, Feldenkrais, Rolfing, Alexander Technique, Other:

9. How many alcoholic beverages do you consume on a weekly or monthly basis?

10. Approximately how much water do you drink per day? List your average daily intake.

11. Approximately how many hours of sleep do you get per evening? List your average hours per evening.

12. How much time do you have to dedicate to an individualized program?

WAIVER

I, the undersigned, have read, understand and have answered the above survey/questions fully and truthfully. I'm aware of my responsibilities to consult with my personal physician regarding my participation in a program of progressive physical exercise that can enhance the musculoskeletal and cardiorespiratory systems. I do hereby intend to be legally bound for myself and waive release of any and all rights and claims for damages I may have against the training facility and the health professional administering the exercise program provided to me.

Client Signature: _____ Date:_____

TERMS & PROGRAM POLICIES

1. CANCELLATIONS

The Athletic Movement Club's 24 hour cancellation policy is enforced. Please give at least 24 hours notice of cancellation prior to your schedule session time by calling or texting 714-309-7771 only. Cancellations made after the 24 hour window will be charged to your Pacific Club account. This pertains to all of AMC services: Movement Therapy/Training, Soft Tissue Integration and Structural Integration.

Client Initials : _____

2. LATE POLICY

Clients are responsible for arriving on time to their sessions. AMC is obligated to wait only 15 minutes. After 15 minutes we are not required to lead the remaining of the session and the session may be lost. At which point you will be charged for a no show. Sessions that start late will still end at their original end time. This pertains to all of AMC services: Movement Therapy/Training, Soft Tissue Integration, Structural Integration. If you are late for a soft tissue session it will be at the discretion of the practitioner as to whether the session can proceed without compromising the integrity of the session's intent. If the session can not proceed you may be charged for the full price of the session.

Client Initials **:** _____

3. PROGRAM POLICY:

The program policies below apply to Movement Therapy/Training. Programs are available for private and partner sessions. All of AMC services are charged to your Pacific Club account. Please check your preferred program below:

_____SESSION-TO-SESSION PROGRAM

This program is NOT based on your preferred days and times, but is based on what is available in the schedule on a week to week basis. You will be charged per session.

Client Initials: _____

_____ 10-SESSION PROGRAM

This is a 5 week program that expires in 6 weeks. The pricing is based on the calendar year, 52 weeks, with 2 sessions per week and 5 weeks off per year, if necessary. It is discounted from the session-to-session program and secures your preferred days and times. Unused sessions within the 6 week period will expire and be forfeited. If AMC misses a session due to vacation, etc. your expiration date will extended accordingly.

Client Initials: _____

_____ MONTHLY RETAINER PROGRAM

This is a month-to-month program based on the calendar year, 52 weeks, with 2 sessions per week for a flat monthly rate. The number of sessions will vary depending on the month and your preferred days of the week. It will average 8.6 sessions per month. Specifics below:

a. This program does not run mid-month to mid-month. It runs from the first to the last day of the month.
b. There are NO late cancellation charges, but please inform AMC 24 hr. in advance of your absence.
c. There are NO extra charges for months that have more than 8 sessions.
d. If have a partner and your partner misses a session, you will NOT be charged for a private session.
e. Adding an extra session to your allotted sessions for the month will incur an additional charge.
f. If AMC misses one or more of your sessions your account will be credited accordingly the following month.
g. The retainer secures your preferred days and times, but there are no refunds for missing your days/times within the month. However, if you have a heavy travel schedule the retainer program is not advisable. The retainer is discounted from the session-to-session and 10-session programs.
h. Please notify AMC if you will be using this program for one month only. If you use this program on a continuous basis, please notify AMC a month prior if you will be vacating your preferred days and times. If you vacate your preferred days/times without notice you will be charged the full retainer price for the following month.

Client Initials: _____

_____STRUCTURAL INTEGRATION (SI) OR SOFT TISSUE THERAPY

This is a soft tissue wellness program. Structural Integration is 10 series of soft tissue work to realign the body. SI must be completed in full. SI can be paid session-to-session or paid in full. Soft tissue therapy is one or more sessions of tissue work and the pricing is also session-to-session.