Health History Intake Form

NAME: ____
DATE:_______________________________

ADDRESS:
____

TOWN: ______________________ ZIP: ______________ PHONE #:
____

PHYSICIAN NAME: ________________________________ PHONE #:
____

IN CASE OF EMERGENCY (NAME): _________________________ PHONE #:
____

DATE of BIRTH ____/____/_____ AGE: ________ HEIGHT: ___________ WEIGHT:
____

Prior to participation in fitness program you must complete the following information to the best of your ability. The data collected from the fitness assessment(s) and your answers to the following questions will help in assessing your physical capacity, thereby aiding in the development of a personalized fitness program.

MEDICAL HEALTH HISTORY
When was your last physical examination performed by a physician? _____________________

Have you ever had a stress test or EKG?
Stress test Yes_______ No________ Physicians Name: _____________________
EKG Yes_______ No_______ Physicians Name: _____________________

Are you currently under a physician's care for an acute or chronic illness? Y __ N __
If yes please explain:
____
____ Physician's Name:
____

Are you currently taking any prescribed medication or dietary supplements? Y __ N __
If yes please list:
____

Please mark an (X) by all current conditions and (P) for all past conditions

______ Allergies
______ Anemia
______ Angina (chest pain)
______ Anxiety
______ Arthritis
______ Arrhythmia
______ Asthma or lung condition
______ Back/Neck Pain
______ Bone/Joint Problems
______ Blood clots
______ Chronic pain
______ Claudication (burning or cramping in legs)
______ Depression
______ Diabetes
______ Difficulty breathing
______ Edema (swelling)
______ Emphysema
______ Epilepsy
______ Fainting
______ Heart disease
______ Heart Murmur
______ Headaches, migraine

______ Hearing problems
______ Hernia
______ High blood pressure
______ Irregular heart rate
  ______ Rapid
  ______ Slow
______ Kidney Disease
______ Ligament injury
______ Low blood pressure
______ Muscle/Tendon injury
______ Numbness/tingling
______ Orthopedic injury
______ Pregnancy
______ Palpitations
______ Sleep difficulties
______ Spinal disorders
______ Stress
______ Stroke
______ Unusual fatigue
______ Vascular Disease
______ Vision problems
______Varicose veins
______ Other

Medical Conditions

______ Heart attack
______ Heart surgery, cardiac catheterization, or coronary angioplasty
______ Pacemaker/implantable cardiac defibrillator/rhythm disturbance
______ Heart valve disease
______ Heart failure
______ Heart transplant
______ congenital heart disease
______ Diabetes
______ Renal disease

Elaborate on noted areas above:

____

____
____
______

____
___

Please list any recent injuries:
____
____
___

When you perform daily activity (i.e. shovel snow, climb stairs, walk) do you experience any of the following?
Shortness of breath_____ Dizziness_____ Headaches_____ Muscle cramps_____ Coughing____
Discomfort in joints_____

Is there any other medical concern that you may have that would prevent you from beginning an exercise program? Yes ____ No ___ if yes explain
____
____
______

HEALTH RELATED BEHAVIOR
Do you smoke cigarettes/pipe/cigars? Yes___ No ___ If yes, how many years_____ per day ______

If you stopped smoking, how long ago did you quit? __________

Do you drink alcohol regularly? Yes___ No ___ If yes, how often__________ much__________

How many hours of sleep do you get per night? ________

PHYSICAL ACTIVITY
Do you exercise regularly now? Yes____ No_____

What type of activity do you take part in?

Activity	Time Spent in Activity	# Times per week
_____________________	_____________________	_____________________
_____________________	_____________________	_____________________
_____________________	_____________________	_____________________
_____________________	_____________________	_____________________

If you previously participated in an exercise program, what was the reason for discontinuing it?

____
____
____
____

Check the category that best describes the type of work you perform?

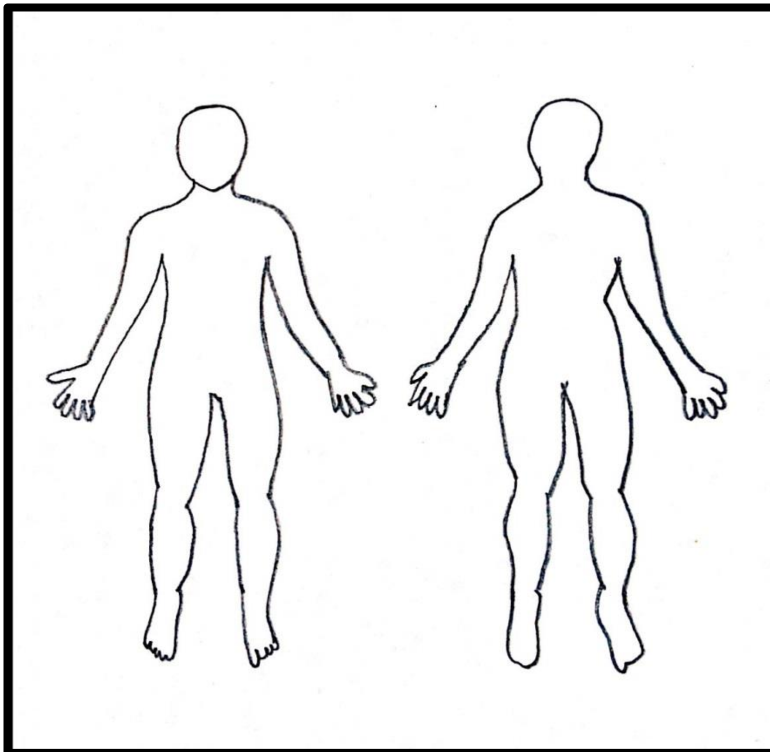
______ Sedentary (sitting or driving)

________Standing (such as a sales clerk)

________Very Active (such as a physician, nurse, etc.)

________Physically Active (laborer)

Please use the letters in the key below to identify any symptoms that you may be currently or have previously experienced. Circle the area around each letter, representing the size and shape of each symptom location.



P= pain or tenderness

S= joint or muscle stiffness

N= numbness or tingling