HYESUNLIFE
DANCE & FITNESS

Health History Questionnaire

[please email completed form to info@hyesunlife.com when completed]

DEMOGRAPHICS:

Date: _____ Age: _____ Weight (lbs): _____

Name: _____ Date of Birth: _____

Home Address: _____ Gender: _____

City & Zip Code:_____ Home Phone: _____ Cell: _____

E-Mail Address: _____ Height: (in.) _____

Occupation (& Company Name): _____

Work Address: _____

Work Telephone: _____

E-mail Address: _____

Emergency Contact (below)

Name: _____

Relationship: _____

Telephone: _____

Name of Personal Physician: _____ Phone: _____

Address: _____ E-mail: _____

Have you been hospitalized, treated for serious illness, or had any surgical procedures in the past 2 years?

☐ Yes ☐ No If you answered yes, indicate the reason for your hospitalization.

MEDICAL HISTORY:

Please check any of the following conditions, which may apply to you. Please be specific when appropriate:

- ☐ Family History of Heart Disease
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Rapid Heart Beat
- ☐ Irregular Heart Beat
- ☐ Angina
- ☐ Stoke
- ☐ Obesity
- ☐ Diabetes
- ☐ Osteoporosis
- ☐ Pregnant
- ☐ Anemia
- ☐ Allergies
- ☐ Arthritis
- ☐ Bursitis
- ☐ Asthma
- ☐ Emphysema
- ☐ Bronchitis
- ☐ Shortness of Breath
- ☐ Lightheadedness or Fainting
- ☐ Cancer
- ☐ Smoking / Tobacco use
- ☐ Alcoholism
- ☐ Unexplained Weight Change
- ☐ Heat Stroke or Illness
- ☐ Stomach Ulcer
- ☐ Epilepsy
- ☐ Thyroid Disorder
- ☐ Gout
- ☐ HIV
- ☐ Joint Inflammation or condition that would make movement, use of certain test modalities difficult
- ☐ Other:_____
- _____
- _____

MEDICATIONS:

Please check any medications you are presently taking and list specific names (generic or trade) when appropriate.

- ☐ High Blood Pressure _____
- ☐ Insulin _____
- ☐ Blood Thinners _____
- ☐ Diuretics _____
- ☐ Diet Pills _____
- ☐ Cholesterol _____
- ☐ Angina _____
- ☐ Allergy _____
- ☐ Asthma_____
- ☐ Thyroid Hormone _____
- ☐ Prostate _____
- ☐ Hormone Replacement _____
- ☐ Pain Reduction _____
- ☐ Polymyalgia _____
- ☐ Other: _____

PREVIOUS INJURIES:

Please check pain or surgery. Be specific with actual dates. Designate left/right when appropriate.

In the past six months:			More than six months:		
Neck	☐ Pain ☐ Surgery	_____	Neck	☐ Pain ☐ Surgery	_____
Shoulder	☐ Pain ☐ Surgery	_____	Shoulder	☐ Pain ☐ Surgery	_____
Elbow	☐ Pain ☐ Surgery	_____	Elbow	☐ Pain ☐ Surgery	_____
Wrist	☐ Pain ☐ Surgery	_____	Wrist	☐ Pain ☐ Surgery	_____
Hand	☐ Pain ☐ Surgery	_____	Hand	☐ Pain ☐ Surgery	_____
Finger	☐ Pain ☐ Surgery	_____	Finger	☐ Pain ☐ Surgery	_____
Back	☐ Pain ☐ Surgery	_____	Back	☐ Pain ☐ Surgery	_____
Hip	☐ Pain ☐ Surgery	_____	Hip	☐ Pain ☐ Surgery	_____
Knee	☐ Pain ☐ Surgery	_____	Knee	☐ Pain ☐ Surgery	_____
Ankle	☐ Pain ☐ Surgery	_____	Ankle	☐ Pain ☐ Surgery	_____
Foot	☐ Pain ☐ Surgery	_____	Foot	☐ Pain ☐ Surgery	_____
Toe	☐ Pain ☐ Surgery	_____	Toe	☐ Pain ☐ Surgery	_____
Other	☐ Pain ☐ Surgery	_____	Other	☐ Pain ☐ Surgery	_____

PARTICIPATION SCREENING QUESTIONNAIRE:

YES NO

☐ ☐ 1. Has a doctor ever said you have a heart condition and recommended only supervised exercise activity?

☐ ☐ 2. Do you have chest pain brought on by physical activity?

☐ ☐ 3. Have you developed chest pain in the past month?

☐ ☐ 4. Have you on one or more occasions lost consciousness or fallen over as a result of dizziness?

☐ ☐ 5. Do you have a bone or joint problem that could be aggravated by the proposed physical activity?

☐ ☐ 6. Has a doctor ever recommended medication for your blood pressure or a heart condition?

☐ ☐ 7. 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?

If you answered 'yes' to any of the above, call your physician or healthcare provider before increasing your physical activity.

☐ ☐ 8. Does your occupation require you to sit for prolonged periods of time?

☐ ☐ 9. Does your occupation require repetitive movement? If yes explain: _____

☐ ☐ 10. Does your occupation require you to wear shoes with a heel (dress shoes)?

☐ ☐ 11. Does your occupation cause general anxiety (mental stress)?

FAMILY HISTORY:

Please check when appropriate and indicate the age of occurrence as well as which family member.

	Age of occurrence	**Family member(s)**
☐ Death before age 60	_____	_____
☐ Heart Disease	_____	_____
☐ High Blood Pressure	_____	_____
☐ Diabetes	_____	_____
☐ Stroke	_____	_____
☐ Obesity	_____	_____
☐ Asthma	_____	_____

☐ Emphysema _____ _____

☐ Cancer (specify type) _____ _____

☐ Other _____ _____

PHYSICAL ACTIVITY INVENTORY:

1. I would rate my daily energy level as (circle):

   (Low) 1 2 3 4 5 6 7 8 9 10 (High)

2. Approximately how many hours per night do you sleep? (circle)

   (Low) 1 2 3 4 5 6 7 8 9 10+ (High)

3. Which of the following best describes your current activity level?

   ☐ Inactive

   ☐ Light Physical Activity

   ☐ Moderate Physical Activity

   ☐ Vigorous Physical Activity

4. Describe any physical activities which you have participated in during the past 12 months:

Activity	Frequency	Duration	Weeks/months consistent

5. Describe any condition and/or problem you have which may affect your ability to participate in strenuous physical activity. _____

_____

_____

_____

GOALS & EXPECTATIONS:

What do you wish to accomplish at Hyesun Fitness?

Please order from most important (#1) to least important (#23). Feel free to mark all twenty-three or just one.

	General Health and Fitness		Injury Prevention
	Weight Loss		Improve Flexibility
	Lower Blood Pressure		Improve Muscle Tone
	Increase Cardio-Respiratory Endurance		Strength Gain
	Stress Reduction		Weight Gain
	Injury Rehabilitation		Enhance Athletic Ability
	Reduce Risk of Disease		Stop Smoking
	Improve Balance and Coordination		Improve Sleep Quality
	Improve Posture		Exercise More Regularly
	Improve Efficiency of Workout Program		Improve Motivation
	Improve Eating Habits		Strengthen Bones
	Other		

SHORT-TERM GOALS: (12 weeks)

Please list your short-term goals while with Hyesun Fitness. Please be specific and detailed as possible so we can truly understand what you want in your exercise program.

_____

_____

_____

LONG-TERM GOALS: (6 months or more)

As above, list your long-term goals while at Hyesun Fitness while being as specific and detailed as possible.

_____

_____

_____

WAIVER OF LIABILITY / INFORMED CONSENT FORM:

I understand and am aware that fitness activities involve a risk of injury and even death and that I am voluntarily participating in these activities and using equipment with knowledge of the dangers involved. I do hereby declare myself in good physical condition and do not suffer from any condition or impairment that would prevent or limit my participation in an exercise program.

Please Initial: _____

In consideration for my being permitted to participate in the activities and programs of HyesunLife LLC, I hereby release HyesunLife LLC and its officers, agents or employees, and any of its related companies and subsidiaries, agents or employees, and agree to hold any and all the released individuals or entities harmless against any liability out of my participation in any of the activities and programs or use of its fitness facilities. **Please Initial: _____**

I hereby affirm that I have read and fully understand this form and give my informed consent to participate in the recommended exercise program(s).

Client Signature: _____ Date: _____
Parent/Guardian Signature: _____ Date: _____