VITA FITNESS

CLIENT SCREEN HEALTH QUESTIONNAIRE

Basic Information

Full Name (First, Last) _____/_____

Gender _____

Date of Birth Y_____/ M_____/ D_____

Age_____

Phone (Home) _____

Phone (Cell) _____

Address_____

City_____

Postal Code_____

Email_____

Emergency Contact

Full Name (First, Last) _____/_____

Relationship _____

Phone (Home) _____

Phone (Cell) _____

PHYSICAL ACTIVITY READINESS QUESTIONNAIRE (PAR-Q)

1. Has your doctor ever said that you have a heart condition and that you should only perform physical activity recommended by a doctor?

(Y/N)

2. Do you feel pain in your chest when you perform physical activity?

(Y/N)

3. In the past month, have you had chest pain when you were not performing any physical activity?

(Y/N)

4. Do you lose your balance because of dizziness or do you ever lose consciousness?

(Y/N)

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5. Do you have a bone or joint problem that could be made worse by a change in your physical activity?

(Y/N)

6. Is your doctor currently prescribing any medication for your blood pressure or for a heart condition?

(Y/N)

7. Do you know of any other reason why you should not engage in physical activity?

_____

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_____

GENERAL/MEDICAL QUESTIONNAIRE

1. What is your current occupation?

_____

_____

2. Does your occupation require extended periods of sitting?

(Y/N)

3. Does your occupation require extended periods of repetitive movements? (If yes, please explain.)

_____

_____

_____

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

(Y/N)

5. Does your occupation cause you anxiety (mental stress)?

(Y/N)

6. Are you a smoker? (If yes, how many per day)

(Y/N)

_____

7. Do you partake in any recreational activities (golf, tennis, skiing, etc.)? (If yes, please explain.)

_____

_____

_____

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8. Do you have any hobbies (reading, gardening, working on cars, exploring the Internet, etc.)? (If yes, please explain.)

_____

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_____

9. What kind of music do you like to workout to (if any?)

_____

_____

Medical Questions

1. Have you ever had any pain or injuries (ankle, knee, hip, back, shoulder, etc.)? (If yes, please explain.) (Y/N)

_____

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2. Have you ever had any surgeries? (If yes, please explain.) (Y/N)

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3. Has a medical doctor ever diagnosed you with a chronic disease, such as coronary heart disease, coronary artery disease, hypertension (high blood pressure), high cholesterol or diabetes? (If yes, please explain) (Y/N)

_____

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_____

4. Are you currently taking any medication? (If yes, please list.) (Y/N)

_____

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If you have answered "Yes" to one or more of the above questions, consult your physician before engaging in physical activity. Tell your physician which questions you answered "Yes" to. After a medical evaluation, seek advice from your physician on what type of activity is suitable for your current condition.