



## Health History Questionnaire

Please answer every question as accurately as possible. Your responses will be treated in a confidential manner.

### A) Client Demographics

Name: \_\_\_\_\_

Address: \_\_\_\_\_ ZIP: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Mobile Phone: \_\_\_\_\_

Fax #: \_\_\_\_\_

E-mail: \_\_\_\_\_

D.O.B. \_\_\_\_\_

Gender: Male: \_\_\_\_\_ Female: \_\_\_\_\_

#### Contacts:

Doctor: \_\_\_\_\_

Phone: \_\_\_\_\_

Hospital: \_\_\_\_\_

Fax #: \_\_\_\_\_

#### Contact In Case of an Emergency:

Name: \_\_\_\_\_

Phone: \_\_\_\_\_

### B) Coronary Artery Disease (CAD) Risk Factors

1) Are you a male older than 45 years? Yes\_\_\_\_ No\_\_\_\_ or a Female older than 55 years who has experienced premature menopause without estrogen replacement therapy? Yes\_\_\_\_ No\_\_\_\_

2) Do you have a father or brother who has had a heart attack or sudden death before the age of 55?\_\_\_\_  
A mother or sister who has had a heart attack or sudden death before 65? Yes\_\_ No\_\_\_\_

3) Do you smoke? Yes \_\_\_\_No \_\_\_\_ If yes, how many cigarettes per day? \_\_\_\_\_

4) Do you have diabetes? \_\_\_\_\_ If yes, type I (juvenile) or type II (adult onset)? \_\_\_\_\_

5) Do you have high blood pressure (or currently medicated for high blood pressure)? \_\_\_\_\_

6) Do you have high cholesterol (or currently medicated for high cholesterol)? \_\_\_\_\_

7) Do you lead a sedentary lifestyle (inactive job and no active lifestyle or recreational pursuits)? \_\_\_\_\_

## Health History Questionnaire (continued)

### C) Known Diseases and Symptoms

#### Known Diseases

Do you have any personal history of coronary or atherosclerotic disease? \_\_\_\_\_

Any personal history of metabolic disease (thyroid, renal (kidney), liver)? \_\_\_\_\_

Do you have diabetes? \_\_\_\_\_ For how many years? \_\_\_\_\_

#### Suggestive Symptoms:

Have you been diagnosed with or exhibited symptoms of any of the following conditions:

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Angina                      | <input type="checkbox"/> Shortness of Breath  | <input type="checkbox"/> Asthma                 |
| <input type="checkbox"/> Rapid Heart Rate            | <input type="checkbox"/> Ankle Edema          | <input type="checkbox"/> Dizziness or Fainting  |
| <input type="checkbox"/> Breathing Problems at Night | <input type="checkbox"/> Known Heart Murmur   | <input type="checkbox"/> Claudication           |
| <input type="checkbox"/> Cardiac Surgery             | <input type="checkbox"/> Vascular Disease     | <input type="checkbox"/> Respiratory Infections |
| <input type="checkbox"/> Abnormal EKG                | <input type="checkbox"/> Thrombophlebitis     | <input type="checkbox"/> Epilepsy               |
| <input type="checkbox"/> Embolism                    | <input type="checkbox"/> Fixed Rate Pacemaker | <input type="checkbox"/> Internal Defibrillator |
| <input type="checkbox"/> Aneurysm                    | <input type="checkbox"/> Valve Disease        | <input type="checkbox"/> Emphysema              |
| <input type="checkbox"/> Stroke                      | <input type="checkbox"/> Anemia               |   |

If you checked off any of the above conditions, please explain: \_\_\_\_\_

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Has your doctor ever recommended/prescribed any medication for blood pressure/heart condition? \_\_\_\_\_

If yes, please explain: \_\_\_\_\_

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Are you taking any other prescription or non-prescription medications? \_\_\_\_\_

If yes, please explain: \_\_\_\_\_

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## Health History Questionnaire (continued)

Do you have any other non-cardiac related conditions or diseases? \_\_\_\_\_

If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List the date of your last physical examination: \_\_\_\_\_

Would you be willing to provide us with a copy of the blood chemistry panel? \_\_\_\_\_

### D) Injuries or Other Orthopedic Limitations

Check the areas that have been injured both recently and in the past. If you DO check, please specify "right or left" if appropriate, and explain.

<input type="checkbox"/> Neck	<input type="checkbox"/> Shoulder	<input type="checkbox"/> Hip	<input type="checkbox"/> Arthritis
<input type="checkbox"/> Spine	<input type="checkbox"/> Elbow	<input type="checkbox"/> Knee	<input type="checkbox"/> Bursitis
<input type="checkbox"/> Lower Back	<input type="checkbox"/> Wrist	<input type="checkbox"/> Ankle	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Spinal Stenosis	<input type="checkbox"/> Degenerative Disc Disease	<input type="checkbox"/> Nerve Damage	<input type="checkbox"/> Other

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are you presently receiving physical therapy, chiropractic, or any other form of rehabilitative therapy?

If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_

May we contact your therapist? \_\_\_\_\_

Therapist Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Are you aware of any medical or other personal limitations not covered by this questionnaire, which would restrict your participation in a program of physical activity? Yes \_\_\_ No \_\_\_

If yes, please specify \_\_\_\_\_

## Health History Questionnaire (continued)

### E) Your Health and Exercise Interests

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Weight Training    | <input type="checkbox"/> Massage Therapy                 | <input type="checkbox"/> Nutritional Counseling  |
| <input type="checkbox"/> Running            | <input type="checkbox"/> Walking                         | <input type="checkbox"/> Yoga/Tai Chi/Meditation |
| <input type="checkbox"/> Pilates            | <input type="checkbox"/> Cycling                         | <input type="checkbox"/> Swimming                |
| <input type="checkbox"/> Golf               | <input type="checkbox"/> Tennis                          | <input type="checkbox"/> Stretching              |
| <input type="checkbox"/> Competitive Sports | <input type="checkbox"/> Rehabilitative Exercise Therapy | <input type="checkbox"/> Aqua aerobics           |

### F) Health and Fitness Objectives

Please list your short-term goals (2 to 4 months)

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Please list your long-term goals (8-12 months and beyond)

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### G) Additional Information

What is your height? \_\_\_\_\_ What is your current weight? \_\_\_\_\_

At what body weight did you, or would you, feel best at? \_\_\_\_\_

How would you characterize your current lifestyle?

Highly Stressful \_\_\_\_\_ Moderately Stressful \_\_\_\_\_ Low in Stress \_\_\_\_\_

*Mobile Health and Fitness has requested the above information for informational purposes only. We do not purport to render medical advice to client. If you have questions about the appropriateness of any activity or program, in light of your medical history, please contact your physician.*

## Release of Liability Waiver

Because physical exercise can be strenuous and subject to risk of serious injury, we urge you to obtain a physical examination from a doctor before using any exercise equipment or participating in any exercise activity. You agree that by participating in physical exercise, physical therapy, massage therapy, or dietary counseling activities, you do so entirely at your own risk. Any recommendation for changes in diet by Mobile Health & Fitness will come from a registered dietician. Additional recommendations for food supplements, or weight reduction products, are entirely your responsibility and you should consult a physician prior to undergoing any dietary or food supplement changes. You agree that you are voluntarily participating in these activities and assume all risks of injury, illness, or death.

You acknowledge that you have carefully read this "waiver and release" and fully understand that it is a release of liability. You expressly agree to release and discharge the trainer or therapist from any and all claims or causes of action and you agree to voluntarily give up or waive any right that you may otherwise have to bring a legal action against the trainer or therapist for personal injury or property damage. To the extent that statute or case law does not prohibit releases for negligence, this release is also for negligence.

If any portion of this release from liability shall be deemed by a Court of competent jurisdiction to be invalid, then the remainder of this release from liability shall remain in full force and effect and the offending provision or provisions severed here from.

By signing this release, I acknowledge that I understand its content and that this release cannot be modified orally.

**Signed:** \_\_\_\_\_

**Printed Name:** \_\_\_\_\_

**Dated:** \_\_\_\_\_

## Contract and Cancellation Notice Agreement

I, \_\_\_\_\_ retain Mobile Health & Fitness to render exercise therapy, physical therapy, massage therapy, and/or dietary counseling services for me. In exchange and consideration for such services, I agree to pay \$ \_\_\_\_\_ per appointment.

After payment, an account will be set up in my name with Mobile Health & Fitness. The amount indicated above will be deducted from my account after each appointment and I will receive an itemized invoice notifying me of payment when my account reaches zero.

Each of the indicated appointments shall be \_\_\_\_\_ minutes in duration.

I understand that I may cancel any appointment with my trainer by giving him or her 24 hours notice. I also understand that if I fail to provide the aforementioned cancellation notice, as indicated, I will be charged for the full session fee.

**Client Signature** \_\_\_\_\_

**Date** \_\_\_\_\_

**Therapist/Trainer** \_\_\_\_\_

**Date** \_\_\_\_\_

*Thank you for taking the time to complete this questionnaire*