Pre-Activity Medical Questionnaire

Date of visit: ______________________
Name: __________________________________ Date of birth: ______________________
Address: ____ City: ______________________
Postal Code: ___________________
Home Phone: (   ) _______________________Work Phone: (   ) _______________________
Cell: (   ) _______________________ email: ____
Occupation: _______________________

Emergency Contact: __________________ Phone: (   ) _________________
Name of your Physician: __________________ Phone: (   ) _________________

1. Have you ever been diagnosed as having any of the following conditions?

	Yes (X)	Year of onset (approx.) - details
Heart Attack	___	____
Diabetes	___	____
Transient ischemic attack	___	____
Angina (chest pain)	___	____
High BP (>140/90)	___	____
Low BP (<100/60)	___	____
High cholesterol	___	____
Stroke	___	____
Lung Disease	___	____
Polio/post polio syndrome	___	____
Epilepsy/seizures	___	____
Other neurological conditions	___	____
Rheumatoid arthritis	___	____
Other arthritic conditions	___	____
Visual/depth perception problems	___	____
Inner ear problems	___	____
Chemical dependency	___	____
Osteoporosis/osteopenia	___	____
If so, date of last DXA and result:		____

	Yes (X)	Year of onset (approx.)
Incontinence w/ exercise	___	______________________________
Depression	___	______________________________
Cancer	___	______________________________
Joint replacement	___	______________________________
Other	___	______________________________

2. Do you currently have any medical conditions for which you see a physician regularly?
   If yes, please describe the condition(s) ______________________________

3. Do currently suffer any of the following symptoms in your legs or feet?
   Numbness __________ Arthritis __________
   Tingling __________ Swelling __________

4. Do you require eyeglasses? Y N
   Do you require hearing aids? Y N
   Do you use an assistive device for walking? Y N Sometimes
   Type? __________

5. Have you ever injured or experienced pain in the following areas?

	Yes (X)	Type of injury/pain and date:
Neck	___	______________________________
Upper back	___	______________________________
Lower back	___	______________________________
Shoulders	___	______________________________
Wrists/fingers	___	______________________________
Elbows	___	______________________________
Hips	___	______________________________
Knees	___	______________________________
Ankles/shins	___	______________________________
Other (describe)	___	______________________________

6. Do you currently work with any of the following practitioners?

__ Chiropractor __ Osteopath __ Massage Therapist __ Other: __________

If so, for what condition? ______________________________

7. List all medication/supplements that you currently take:

Type of medication/supplement	For what condition
______________________	__________________________
______________________	__________________________
______________________	__________________________
______________________	__________________________
______________________	__________________________

8. Which of the following best describes your activity levels at work?

- Primarily inactive (e.g., professional, desk job) _____
- Lightly active (e.g., nurse) _____
- Heavily active (e.g., laborer) _____

9. Listed below are several goals that can be achieved with regular exercise. Please rate how important each is to YOU on a scale of 1 to 10 (1 low, 10 high).

Feel healthier _______	Increase energy levels _________
Improve strength _______	Increase muscle size _________
Improve muscle tone _______	Increase aerobic fitness _________
Reduce muscle fat _______	Improve flexibility _________
Improve sport performance _______	Recover from injury _________
Prevent injury _______	Prevent stress _________
Look better _______	Lose weight _________
Gain weight _______	Improved sleep ________

10. Describe your exercise profile **over the past 3 months** (e.g., your level of physical fitness participation in sports/activities/ hobbies)

____

____

11. What is the current distance you can comfortably walk continuously?

____

12. Describe your level of participation in sports/activities over the course of your life:

Childhood/teen:

____

20's:

____

30's:

____

40's:

____

50's (plus):

____

____

____

What are your TOP 5 health and fitness priorities?

- ____
- ____
- ____
- ____
- ____

My most important goal is:

____

Thank you for sharing this information. It will help me to assist you in achieving your goals.