**South Bellevue Community Center**

Health History Questionnaire –

Personal Training/Fitness Assessment

**Fitness Assessment/Body Composition Analysis Pretest Instructions:**

(These do not pertain to the consultation with one of our Personal Trainers!)

* Wear shorts or loose fitting sweatpants allowing access to a bare thigh

**Best to test:**

* After 7+ hours of sleep
* 2-4 hours after last meal
* 4+ hours after tobacco, caffeine, alcohol
* 6+ hours after last workout
* When fully hydrated

The purpose of the Health History Questionnaire - Personal Training/Fitness Assessment is to gather health history information to determine whether or not a Physician's written consent will be required before participation in a fitness assessment or personal training session. While we are happy to work with you to develop an exercise program and to complete a physical assessment, please note that certified personal trainers are not licensed physicians or medical providers. We cannot provide medical advice, treatment or services to you. You must consult with your own medical provider for services of this nature.

The completed questionnaire will be maintained as a confidential record in a locked cabinet that is only accessible by the Fitness/Wellness Coordinator or Certified Personal Trainer.

Name       Date   /  /

**Specific Health Goals - Please check all that apply:**

Reduce Stress

Control Blood Pressure

Feel better Overall

Increase Productivity

Improve Nutritional Habits -Control Cholesterol

Decrease Back Pain

Stop Smoking

Achieve Better Balance in Life

Increase Health Awareness

**Specific Fitness Goals - Please check all that apply:**

Increase Strength and Endurance

Increase Cardio Fitness

Increase Flexibility

Exercise Regularly

Increase Muscle Tone

Increase Muscle Mass

Decrease Body Fat

Injury Rehab (specify):

Sport Condition (specify):

Other

Interested in Personal Training?

Interested in Fitness Assessment?

**IMPORTANT ~ PLEASE COMPLETE BEFORE CONTINUING!**

**PAGES 4 – 6: "HEALTH HISTORY QUESTIONNAIRE" AND**

**PAGE 3 : “PHYSICIAN REFERRAL FORM” if you meet any of the following criteria**

On the Health History Questionnaire, you have a YES response to questions 1 through 9.

You are a man 45 or older or a woman 55 or older, AND you have one or more YES responses to questions 10 through 15. For question 16, because it is not written as a “YES/NO” question, please note that a sedentary lifestyle counts as one “YES” and a BMI (Body Mass Index) of 30 or more counts as one “YES” towards your total count. (See BMI chart on 2nd page to calculate yours).

You are a man 44 or younger or a woman 54 or younger AND you have two or more YES responses to questions 10 through 15. For question 16, because it is not written as a “YES/NO” question, please note that a sedentary lifestyle counts as one “YES” and a BMI (Body Mass Index) of 30 or more counts as one “YES” towards your total count. (See BMI chart on 2nd page to calculate yours).

I have read, understood, and completed the Health History Questionnaire. I certify that the above information is true and correct to the best of my knowledge. All of my questions were answered to my full satisfaction. Please place a check-mark next to the statement below that applies to you:

Because I do not meet any of the above criteria, I hereby consent to voluntarily participate in a Fitness Assessment and/or Personal Training Session{s) at the South Bellevue Community Center.

Because I meet one or more of the above criteria, I have obtained medical clearance to participate in a Fitness Assessment and/or Personal Training Session{s) at the South Bellevue Community Center. (Doctor-completed Physician Referral Form attached.)

Name       Date  /  /

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Table 6.8**  **Body Mass Index** | | | | | | | | | | | | | | |
|  | **19** | **20** | **21** | **22** | **23** | **24** | **25** | **26** | **27** | **28** | **29** | **30** | **35** | **40** |
| Height  (Inches) | Weight  (pounds) | | | | | | | | | | | | | |
| **58** | 91 | 95 | 100 | 105 | 110 | 115 | 119 | 124 | 129 | 134 | 138 | 143 | 167 | 191 |
| **60** | 97 | 102 | 107 | 112 | 118 | 123 | 128 | 133 | 138 | 143 | 148 | 153 | 179 | 204 |
| **62** | 104 | 109 | 115 | 120 | 125 | 131 | 136 | 142 | 147 | 153 | 158 | 164 | 191 | 218 |
| **64** | 110 | 116 | 122 | 128 | 134 | 140 | 145 | 151 | 157 | 163 | 169 | 174 | 203 | 233 |
| **66** | 117 | 124 | 130 | 136 | 142 | 148 | 155 | 161 | 167 | 173 | 179 | 185 | 216 | 247 |
| **68** | 125 | 131 | 138 | 144 | 151 | 158 | 164 | 171 | 177 | 184 | 190 | 197 | 230 | 263 |
| **70** | 132 | 139 | 146 | 153 | 160 | 167 | 174 | 181 | 188 | 195 | 202 | 209 | 243 | 278 |
| **72** | 140 | 147 | 155 | 162 | 169 | 177 | 184 | 191 | 199 | 206 | 213 | 221 | 258 | 294 |
| **74** | 148 | 155 | 163 | 171 | 179 | 187 | 194 | 202 | 210 | 218 | 225 | 233 | 272 | 311 |
| **76** | 156 | 164 | 172 | 180 | 189 | 197 | 205 | 213 | 221 | 230 | 238 | 246 | 287 | 328 |
| Note: Find your height in the far left column and move across the row to the weight that is closest to your weight. Body mass index will be at the top of that column. | | | | | | | | | | | | | | |

**Physician Referral**

Date Faxed/Sent to Physician

Patient:       Physician:

Birth Date:       Phone: (   )   -     Ext.

Phone:       Fax: (   )   -

Dear Doctor,

Your patient has requested to participate in an exercise program. This referral is requested for establishing medical clearance to provide initial fitness assessments for beginning an exercise program.

Due to the reasons listed below, we are requesting medical clearance for your patient. Please complete the following form and state to the best of your ability if there are any contraindications or recommendations for participation in the testing procedures or exercise program. This form is administered based on established guidelines of the ACSM (American College of Sports Medicine). This referral is valid only if the client remains on the same medications (type and dose), and is in the same clinical status as on the day of the fitness assessment. The client has signed a statement that it is his/her responsibility to inform the trainer of any changes in their health status. Thank you.

Primary Risk Factors noted on Health History Questionnaire:

elevated cholesterol

sedentary

age (males>45/women > 55)

BMI ≥ 30

cigarette smoking

metabolic disease

family history

signs or symptoms

high BP/BP meds

CV disease

pregnancy

Other information:

**Based on the information provided and any other information you, the physician, may have concerning your client, your recommendations for exercise (check ONE):**

1.  is **NOT CLEARED** and cannot exercise at this time.

2.  is CLEARED and can exercise with no restrictions

3.  is CLEARED with the following RESTRICTIONS,

Physician's Signature Date   /  /

**Please return within 1 week from date noted above.**

**Health History Questionnaire**

Please answer the following questions to the best of your ability. For the following questions, unless otherwise indi­cated, circle the single best choice for each question. As is customary, all of your responses are completely confi­dential and may only be used in group summaries and/or reports. All information collected is subject to the Privacy Act of 1974. If you have any physical handicaps or limitations that would require special assistance with this ques­tionnaire, please let your trainer know. This form is in accordance with the American College of Sports Medicine guidelines for risk stratification when followed correctly by your trainer. Your trainer should be certified with a national organization in order to use these forms correctly.

Name:       Ht.:       Wt.:

Gender:  Age:     Birthdate:   /  /

Address:

City:       State:    ZIP:       Phone: (   )   -

Emergency Contact:       Phone: (   )   -

Personal Physician:       Phone: (   )   -

E-mail:

1. Have you ever had a definite or suspected heart attack or stroke?  Yes  No

2. Have you ever had coronary bypass surgery or any other type of heart surgery?  Yes  No

3. Do you have any other cardiovascular or pulmonary (lung) disease ***(other than*** asthma, allergies, or mitral valve prolapse)?  Yes  No

1. Do you have a history of:  diabetes,  thyroid,  kidney,  liver disease  Yes  No

**(check all the above that apply)**

1. Have you ever been told by a health professional that you have had an abnormal resting or exercise (treadmill) electrocardiogram (EKG)?  Yes  No
2. If you answered YES to any of Questions 1 through 5, please describe:

7. Do you currently have any of the following:

1. pain or discomfort in the chest or surrounding areas that occurs when you engage in physical activity?

Yes  No

1. shortness of breath  Yes  No
2. unexplained dizziness or fainting  Yes  No
3. difficulty breathing at night except in upright position  Yes  No
4. swelling of the ankles (recurrent and unrelated to injury)  Yes  No
5. heart palpitations (irregularity or racing of the heart on more than one occasion)  Yes  No
6. pain in the legs that causes you to stop walking (claudication)  Yes  No

h. known heart murmur  Yes  No

Have you discussed any of the above with your personal physician?  Yes  No

1. Are you pregnant or is it likely that you could be pregnant at this time?  Yes  No

If yes, what is your expected due date?   /  /

1. Have you had surgery or been diagnosed with any disease in the past 3 months?  Yes  No

If yes, please list date,   /  /     and surgery/disease

1. Have you had high blood cholesterol or abnormal lipids within the past 12 months or are you taking medication to control your lipids?  Yes  No

11. Do you currently smoke cigarettes or have quit within the past 6 months?  Yes  No

1. Have your father or brother(s) had heart disease prior to age 55 OR mother or sister(s) had heart disease prior to age 65?  Yes  No
2. Within the past 12 months, has a health professional told you that you have high blood pressure (systolic > 140 OR diastolic > 90)?  Yes  No
3. Currently, do you have high blood pressure or, within the past 12 months, have you taken any medicines to control your blood pressure?  Yes  No
4. Have you ever been told by a health professional that you have a fasting blood glucose greater than or equal to 100 mg/dl?  Yes  No
5. Describe your regular physical activity or exercise program:

Type:

Frequency:       days per week

Duration:      minutes

Intensity:

BMI:

1. If you have answered YES to any of questions 7-16, please describe:
2. Are you currently under any treatment for any blood clots?  Yes  No
3. Do you have problems with bones, joints, or muscles that  
   may be aggravated with exercise?  Yes  No
4. Do you have any back/neck problems?  Yes  No
5. Have you been told by a health professional that you should not exercise?  Yes  No
6. Are you currently being treated for any other medical condition by a physician?  Yes  No
7. Are there any other conditions (mitral valve prolapse, epilepsy, history of rheumatic fever, asthma, cancer, anemia, hepatitis, etc.) that may *hinder* your ability to exercise?  Yes  No
8. During the past six months, have you experienced any ***unexplained*** weight loss or gain (greater than ten pounds for no known reason)?  Yes  No
9. If you have answered YES to any of questions 18-24, please describe:
10. Please list below all prescription and over-the-counter medications you are currently taking:

Medicine Reason for Taking Dosage Amount/Frequency

1. Are there any medicines that your physician has prescribed to you in the past 12 months which you are currently not taking?  Yes  No

If so, please list:

I have answered the Health History Questionnaire questions accurately and completely. I understand that my medical history is a very important factor in the development of my fitness/wellness program. I understand that certain medical or physical conditions which are known to me, but that I do not disclose to my trainer, may result in serious injury to me. If any of the above conditions change, I will immediately inform my trainer of those changes. I, knowingly and willingly, assume all risks of injury resulting from my failure to disclose accurate, complete, and updated information in accordance with the attached questionnaire. I also understand that in order to properly risk stratify my Health History Questionnaire, my trainer should have a minimum of a national certification as a personal trainer. My trainer also verbally explained this statement to me to my understanding.

Client's Signature: Date:

Trainer’s Signature: Date: