

Heath History Questionnaire

Name _____ Date _____

Street Address _____ City _____

Phone (home) _____ (work) _____

E-mail Address _____

Person to contact in case of emergency: _____ Date of birth _____

Name _____ Phone _____

Do you want to be on our email mailing list? Y or N
Address _____

For most people, physical activity should not pose any problem or hazard. The following questions are designed to identify the small number of adults for whom physical activity might be inappropriate or those who should have medical advice concerning the type of activity most suitable for them.

Common sense is your best guide in answering these questions. Please read them carefully and check "Yes" or "No" opposite the question if it applies to you.

Yes No
____ 1. Has your doctor ever said you have heart trouble? If yes, please describe the problem and state when it was diagnosed.

____ 2. Do you frequently have pains in your heart and chest?

____ 3. Do you often feel faint or have spells of severe dizziness?

____ 4. Has a doctor ever told you that your blood pressure was too high?

____ 5. Has your doctor ever told you that you have a bone or joint problem, such as arthritis, that has been aggravated by exercise or might be made worse by exercise?

____ 6. Is there a good physical reason not mentioned here why you should not follow an activity program even if you wanted to do so?

____ 7. Are you over age 65 and/or not accustomed to vigorous exercise?

____ 8. Are you or have you ever been a diabetic?

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___ 9. Are you or have you been pregnant in the last three months?

___ 10. Have you had any surgery in the last three months?

___ 11. Have you been hospitalized in the last two years? If so, when and why?

___ 12. Have you ever seen a chiropractor, acupuncturist, or other alternative medical practitioner?
If so, when and why?

Please check the box if you have ever experienced any of the following symptoms:

- | | <u>When first experienced</u> | <u>Treatment Used</u> |
|---|-------------------------------|-----------------------|
| <input type="checkbox"/> Pain or discomfort in the chest | | |
| <input type="checkbox"/> Unaccustomed shortness of breath | | |
| <input type="checkbox"/> Dizziness | | |
| <input type="checkbox"/> Labored or uncomfortable breathing,
With or without pain | | |
| <input type="checkbox"/> Swollen ankles | | |
| <input type="checkbox"/> Heart palpitations | | |
| <input type="checkbox"/> Heart murmur | | |
| <input type="checkbox"/> Limping | | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have high blood pressure? If yes, what is your current blood pressure without medication? _____ | | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Are you taking any medication for hypertension? If so, what medication? _____ | | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Is your total serum cholesterol level over 240? | | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Do you smoke? | | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Have you ever smoked? If so, when did you quit? _____ | | |

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Yes No Do you have a family member who has had coronary or arteriosclerotic disease prior to age 55?

Yes No Do you have pain or discomfort in your back?

Yes No Do you have pain or discomfort in your knee? If so, right or left?

Yes No Do you have pain or discomfort in your shoulder? If so, right or left?

Yes No Do you have pain or discomfort in your elbow? If so, right or left?

Yes No Do you have pain or discomfort in your wrist? If so, right or left?

Yes No Do you have pain or discomfort in your ankle? If so, right or left?

If you checked "yes" above, please describe your pain. On a scale of 1 to 10, with 1 being nonexistent and 10 being excruciating, how severe is it? Does it get more or less severe as the day goes on? When do you notice it? What really aggravates it?

Yes No Have you ever torn ligaments or cartilage in your knee? If so, when? _____
Did you have surgery on this knee? If so, when? _____

Yes No Have you ever dislocated your shoulder? If so, when?

Yes No Have you ever had shoulder surgery? If so, when?

Yes No Have you ever had a neck injury, such as whiplash? If so, when?

Yes No Have you ever been treated for spinal disc injury? If so, when?

Yes No Do you ever experience tingling or numbness in your elbows or hands?

What is the present state of your general health? _____

What regular physical activities do you do now? _____

How often? _____ For how long each session? _____

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I, _____, certify that I have the foregoing questions and my answers are true and complete. I also understand that this information is being provided as part of my initial consultation and may not be periodically updated.

I, _____, assume the risk for any charges in my medical condition that affect my ability to exercise.

Signature

Date

If you answered "yes" to one or more questions and you have not recently done so, consult with your doctor before beginning an exercise program. Tell your doctor which questions you answered "yes" to and explain that you plan to undergo an exercise program that may include, but not be limited to, weight and/or resistance training. After medical evaluation, ask your doctor

which activities you may safely participate in and what specific restrictions, if any, should apply to your condition and which activities and/or exercises you should avoid.

I, _____, acknowledge that I have read the foregoing statements and understand the content thereof.

Signature

Date

The following information and statements are not the direct words of TJ FIT INC and are those of T. O'Brien. New silhouette- the science of physiology, the art of body sculpting

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