Three Corners Health Services Society

Fitness Assessment Questionnaire

I. Participant information

Last Name: Click here to enter text.	First Name: Click here to enter text.
Gender: Male ☐ Female ☐	Date of Birth:Click here to enter a date.
Phone #: Click here to enter text.	Cell Phone: (if different) Click here to enter text.
Email address: Click here to enter text.	Contact Preference: Phone ☐ Email ☐ Other ☐ If other, please specify: Click here to enter text.
Address: Click here to enter text.	Community:Click here to enter text.
Emergency Contact (name): Click here to enter text.	Emergency Contact: (phone #) Click here to enter text.

Availability Chart:

Please complete the availability log below. Place an "x" in the time slots that you ARE available.

	Monday	Tuesday	Wednesday	Thursday	Friday
8:00 am					
9:00 am					
10:00 am					
11:00 am					
12:00 pm					
1:00 pm					
2:00 pm					
3:00 pm					
4:00 pm					
5:00 pm					
6:00 pm					

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II. Health History

Assess your health status by marking all the true statements:

History You have had: _____ a heart attack _____ heart surgery _____ cardiac catheterization _____ coronary angioplasty (PTCA) _____ pacemaker/implantable cardiac defibrillator/rhythm disturbance _____ heart valve disease _____ heart failure _____ heart transplantation _____ congenital heart disease **Symptoms** _____ You experience chest discomfort with exertion _____ You experience unreasonable breathlessness _____ You experience dizziness, fainting, or blackouts _____ You take heart medications **Other Health Issues** _____ You have diabetes _____ You have asthma or other lung disease _____ You have burning or cramping sensation in your lower legs when walking short distances _____ You have musculoskeletal problems that limit your physical activity _____ You have concerns about the safety of exercise _____ You take prescription medication(s) _____ You are pregnant	*If you marked any of the statements in this section, approval from your physician or other appropriate health care provider is required before engaging in our personal training program.*
Cardiovascular Risk Factors _____ You are a man older than 45 years _____ You are a woman older than 55 years, have had a hysterectomy, or are postmenopausal _____ You smoke, or quit smoking within the previous 6 months _____ Your blood pressure is >140/90 mm Hg _____ You do not know your blood pressure _____ You take blood pressure medication _____ Your blood cholesterol is >200mg/dL _____ You do not know your cholesterol level _____ You have a close relative who had a heart attack or heart surgery before age 55 (father or brother) or 65 (mother or sister) _____ You are physically inactive (i.e. you get <30 minutes of physical activity on at least 3 days per week) _____ You are > 20 pounds (9 kg) overweight	*If you marked two or more if the statements in this section, approval is required from your physician or other appropriate health care provider in the program.*
_____ None of the above	*You should be able to exercise safely without consulting your medical professional*

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Please answer the following questions thoroughly:

1. Do you have any neck, back, knee, hip, shoulder, or other skeletal problems that will be made worse by or limit your ability to exercise? ☐ No ☐ Yes

   If yes, please explain:

   Click here to enter text.

2. Have you had a recent hospitalization, surgery, or illness? Click here to enter text.

   If yes, please explain:

   Click here to enter text.

3. Please list any other medical issues, past/current injuries, or possible concerns:

   Click here to enter text.

III. Activity Questionnaire & Goal Setting

1. When was the last time that you were physical active?
   ☐ Never ☐ Presently ☐ In the past (dates: __Click here to enter a date._)
2. Please give a brief description of your last or present physical routine, if applicable.

   Click here to enter text.

3. If you are not still following this routine, why did you stop?

   Click here to enter text.

4. What are some of your favourite activities?

   Click here to enter text.

5. Are there certain activities that you avoid due to dislike, discomfort, etc.? Why?
   Click here to enter text.

6. What is your occupation? Please give brief description of possible activities in job.

   Click here to enter text.

7. Please mark on the scale how physically active you are:

On weekdays:

1	2	3	4	5	6	7	8	9	10

On weekends:

1	2	3	4	5	6	7	8	9	10

8. Approximately how much sleep do you get (average hours per night)?

_____ Weekdays _____ Weekends

9. What is your primary reason for wanting to start a fitness routine?

☐Lose Weight ☐Gain weight ☐Feel better ☐Look Better ☐ Other: _____

Please describe your fitness goal:

Click here to enter text.

10. What level of motivation do you have to change your exercise habits?

1	2	3	4	5	6	7	8	9	10

11. Can you foresee any barriers that might interfere with reaching your goals?

Click here to enter text.

12. Do you feel that you need to make any changes to your eating habits?
Click here to enter text.

How confident are you that you can successfully make these changes in your diet, if applicable?

Click here to enter text.

13. What kind of time commitment are you (realistically) planning on dedicating to your fitness program (days/weeks and minutes/session)?

Click here to enter text.

14. What factors contribute to stress in your life and what do you do to manage your stress?

Click here to enter text.