Welcome to HealthWorks Rehab & Fitness!

Thank you for selecting HealthWorks Rehab & Fitness as your fitness facility. We work hard at providing a professional and friendly atmosphere where you can swim, workout, attend group exercise classes, play basketball, or just relax with friends. We are confident that the most productive exercise program begins with a comprehensive evaluation of your current health status, fitness level, and lifestyle. Therefore, we request that you promptly schedule you fitness assessment.

Why take fitness tests? We follow the guidelines published by the American College of Sports Medicine (ACSM) and our testing provides you with important information that will help:

- ✓ **Alert you to risk factors for chronic disease**
- ✓ **Identify possible contraindications to exercise**
- ✓ **Identify a safe starting point for an exercise and/or weight control program**
- ✓ **Measure fitness changes**
- ✓ **Determine an appropriate and safe intensity for workouts**
- ✓ **Enhance your training program to improve your performance**

A Fitness Specialist will take you through the assessment, ensuring that you understand each aspect and its relevance to your exercise needs and lifestyle. During your appointment, the following will be assessed:

✓ **Medical History**	✓ **Exercise History**	✓ **Cardiovascular Fitness**
✓ **Risk Factors for Exercise**	✓ **Body Composition**	✓ **Muscular Strength**
✓ **Personal Goals**	✓ **Flexibility & Posture**	✓ **Muscular Endurance**

For Best Results:

- ✓ **Please wear comfortable, loose fitting shorts and a t-shirt**
- ✓ **Avoid food, tobacco, alcohol, and caffeine at least three hours prior to the assessment**
- ✓ **Do not perform strenuous exercise on the day prior to your assessment**
- ✓ **Get a sufficient amount of rest the night before the assessment**
- ✓ **Please allow 60 minutes for this appointment**

If you are uncertain about how to complete any portion of the paperwork, please leave it blank and our fitness staff will assist you during you appointment. Your appointment is scheduled for:

Our staff is dedicated to providing you with a safe, state-of-the-art, multi-sport exercise facility. We look forward to working with you to develop an exercise program specific to your goals and abilities!

Yours in health and wellness,

Fitness Assessment Appointment

Date:_____

Time:_____

Lindsey Kelenske
Fitness Director

Medical History Questionnaire

Name: _____ **Age:** _____ **Today's Date:** _____

Occupation: _____ **Weight at age 21:** _____

***If you answer "yes" to any questions below, a medical clearance is required prior to participation in the HealthWorks Fitness Program. Even if you answer no to all questions, you may still be required to obtain a medical clearance prior to participation in the HealthWorks Fitness Program.**

Do you consider your occupation: ☐ **Active** ☐ **Moderately Active** ☐ **Sedentary**

Have you ever had or been diagnosed by a physician with any of the following:

- ☐ Coronary Heart Disease
- ☐ Rheumatic Heat Disease
- ☐ Congenital Heart Disease
- ☐ Irregular Heartbeat
- ☐ Heart Valve Problem
- ☐ Heart Murmur
- ☐ Unexplained loss of consciousness
- ☐ Asthma or Pulmonary Problem
- ☐ Dizziness or Syncopy (fainting)
- ☐ Claudication (leg cramps/pain)
- ☐ Excessive shortness of breath during or after physical activity or exertion
- ☐ Heart Attack
- ☐ Stroke
- ☐ Epilepsy
- ☐ Hypoglycemia (Low Blood Sugar)
- ☐ Hypertension (High Blood Pressure)
- ☐ Angina/Chest Pain
- ☐ Unexplained weakness or fatigue
- ☐ Hemophilia or Blood Disorder
- ☐ High Cholesterol or triglycerides
- ☐ Ankle edema (swelling)
- ☐ Orthopnea/Paroxysmal Nocturnal Dyspnea (shortness of breath during sleep)
- ☐ Other:
- ☐ Diabetes: Circle type Type I Type II

Please Explain: _____

_____

Has anyone in your family (father, mother, brother, sister, grandparents) had a heart attack or other heart related problem before the age of 55? ☐ **Yes** ☐ **No**

If yes, please explain: _____

_____

Do you currently have any of the following?

- ☐ Back pain
- ☐ Joint, tendon or muscular pain
- ☐ Allergies
- ☐ Other:

If yes, please explain: _____

_____

Please list all prescription medication(s) presently being taken:

Name	Reason
_____	_____
_____	_____
_____	_____
_____	_____

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Medical History Questionnaire (page 2)

Are there any medications that have been recommended for you that you are not currently taking?

☐ **Yes** ☐ **No**

If yes, please explain: _____

_____

Please list any surgical procedures that you have undergone within the past 12 months.
(Include the approximate date.)

_____

_____

_____

Do you smoke or use smokeless tobacco products?

☐ **No, I don't use either product**

☐ **Smoke** ☐ **Less than 1 pack per day** ☐ **More than 1 pack per day**

☐ **Use smokeless tobacco** ☐ **Less than 1 package per day** ☐ **More than 1 package per day**

Are you now or have you ever been on a diet? ☐ **Yes** ☐ **No**

If yes, please explain: _____

_____

How many meals do you usually eat per day? _____

How many hours of sleep do you average per night? _____

Are you pregnant? ☐ **Yes** ☐ **No** **If yes, how many months?** _____

Have you given birth within the past 12 months? ☐ **Yes** ☐ **No**

If yes, please list type of delivery: _____

I attest that I have answered all the above questions to the best of my ability.

_____ _____

Signature of Participant **Date**

(Signature of Parent/Guardian if the participant is a minor)

Exercise History Questionnaire

Name: _____ **Today's Date:** _____

General Instructions: Please fill out this form as completely as possible.
If you have any questions, DO NOT GUESS; ask a fitness staff employee for assistance.

1. **Please rate your exercise level on a scale of 1 to 5 (5 indicating very strenuous) for each age range through your present age:**

   15-20 _____ **21-30** _____ **31-40** _____ **41+** _____

2. **Were you a high school or college athlete?** ☐ **Yes** ☐ **No**
   If yes, please specify:
   _____

3. **Do you have any negative feelings toward, or have you had any bad experiences with physical activity programs?** ☐ **Yes** ☐ **No**
   If yes, please specify:
   _____

4. **Do you have any negative feelings toward or have you had any bad experiences with fitness testing and evaluation?** ☐ **Yes** ☐ **No**
   If yes, please specify:
   _____

5. **Do you start exercise programs but then find yourself unable to stick with them?**

   ☐ **Yes** ☐ **No**

6. **How much time are you willing to devote to an exercise program?**

   _____ **minutes/day** _____ **days/week**

7. **How long have you been exercising regularly?**

   _____ **months** _____ **years** _____ **N/A**

8. **Are you currently involved in regular endurance (cardiovascular) exercise?**
   ☐ **Yes** ☐ **No**

   If yes, please specify: _____

9. **Rate your perception of the exertion of your cardiovascular exercise program**

   _____ **light** _____ **fairly light** _____ **somewhat hard** _____ **hard**

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HealthWorks Rehab & Fitness

Exercise History Questionnaire (page 2)

10. **Are you currently involved in regular resistance (strength) training?**
    ☐ Yes ☐ No

    If yes, please specify: _____

11. **Rate your perception of the exertion of your resistance training program:**

    _____ light _____ fairly light _____ somewhat hard _____ hard

12. **Would an exercise program benefit your job?** ☐ Yes ☐ No

13. **What types of exercise interest you?**

_____	walking	_____	jogging/running	_____	swimming
_____	aerobics classes	_____	cycling	_____	strength training
_____	racquet sports	_____	stretching	_____	other

    If others, please list: _____

14. **Rank your goals in undertaking exercise: (What do you want exercise to do for you?)**
    Use the following scale to rate each goal separately.
    Write a number in the blank which corresponds with the amount of importance each goal has to you.

Not at all important				Somewhat important				Extremely important	
1	2	3	4	5	6	7	8	9	10

Improve flexibility	_____	Improve cardiovascular fitness	_____
Body-fat weight loss	_____	Improve sports performance	_____
Reshape my body	_____	Lower blood pressure	_____
Increase strength	_____	Improve moods and decrease stress	_____
Improve bone density	_____	Increase feeling of wellness	_____
Increase energy level	_____	Enjoyment	_____
Lower cholesterol	_____	Other: _____	_____

I attest that I have answered all the above questions to the best of my ability.

_____ _____

Signature of Participant **Date**

(Signature of Parent/Guardian if the participant is a minor)