

# Fitness Worx

2835 N. Nebraska Ave.  
York, Nebraska 68467

## Health History Questionnaire

Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_, ST \_\_\_ Zip \_\_\_\_\_

Telephone Home \_\_\_\_\_ Work \_\_\_\_\_ Cellular \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_

Gender-M \_\_\_\_\_ F \_\_\_\_\_ Birth Date \_\_\_\_\_ Age \_\_\_\_\_

Regular physical activity is safe for most people. However, some individuals should check with their doctor before starting an exercise program. To help us determine if you should consult with your doctor before starting to exercise with **Fitness Worx**, please read the following questions carefully and answer each one honestly. All information will be kept confidential. Please check YES or NO:

YES

NO

- |                          |                          |   |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have a heart condition?  |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever experienced a stroke?   |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have epilepsy?   |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you pregnant?   |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have diabetes?   |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have emphysema?  |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you feel pain in your chest when you engage in physical activity?  |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have chronic bronchitis?   |
| <input type="checkbox"/> | <input type="checkbox"/> | In the past month, have you had chest pain when you were not doing physical activity?   |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you ever lose consciousness or do you ever lose control of your balance due to chronic dizziness?                                |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you currently being treated for a bone or joint problem that restricts you from engaging in physical activity?                  |
| <input type="checkbox"/> | <input type="checkbox"/> | Has a physician ever told you or are you aware that you have high blood pressure?   |
| <input type="checkbox"/> | <input type="checkbox"/> | Has anyone in your immediate family (parents/brothers/sisters) had a heart attack, stroke, or cardiovascular disease before age 55? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you currently smoke?   |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you a male over 44 years of age?  |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you a female over 54 years of age?  |

- |                          |                          |   |
|--------------------------|--------------------------|---|
| YES                      | NO                       |   |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you currently exercising LESS than 1 hour per week? If no, please list your activities. _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you currently taking any medication? Please list names and purpose<br>_____                   |

Health History Questionnaire  
Part Two

What are your specific fitness goals at **Fitness Worx**? (Indicate all that apply)

- Increase strength & Endurance
- Improve cardiovascular fitness
- Improve muscle tone
- Reduce body fat
- Increase muscle mass
- Exercise regularly
- Injury Rehabilitation
- Sports conditioning
- Other \_\_\_\_\_

What are your specific health goals at **Fitness Worx**? (Indicate all that apply)

- Reduce stress
- Improve nutritional habits
- Control blood pressure
- Control cholesterol
- Stop smoking
- Achieve balance in life
- Improve productivity
- Reduce back pain
- Feel better overall
- Other (please be specific) \_\_\_\_\_

What motivated you to join **Fitness Worx**? (Indicate all that apply)

- Convenience/location
- Membership promotion
- Peer support
- Medical reasons
- Tried as a guest
- Corporate membership
- Other \_\_\_\_\_

I have read, understood, and completed this questionnaire. Any questions that I had were answered to my full satisfaction.

Name \_\_\_\_\_ Date \_\_\_\_\_

Signature \_\_\_\_\_

**Staff Use Only**

Cleared to exercise \_\_\_\_\_ Not Cleared to exercise \_\_\_\_\_

Reason \_\_\_\_\_

Staff Signature \_\_\_\_\_ Date \_\_\_\_\_

Resting Heart Rate \_\_\_\_\_

Resting Blood Pressure \_\_\_\_\_

EP \_\_\_\_\_