PRE-SCREENING FORM

Name_____Date of Birth_____Age_____Sex: Male Female

Address _____
Street City State Zip

Phone # _____ _____ _____
Home Work Cell

MD/PCP _____
Name Phone #

Emergency Contact _____
Name Relationship to Client Phone #

Height _____ Weight_____email_____ Today's Date_____

PRE-TEST SCREENING QUESTIONNAIRE

1. Are you:
   - Male age 45 or older? YES NO
   - Female age 55 or older? YES NO

2. How would you describe your current level of physical activity?
   - Inactive – just activity of daily living
   - Light – some walking, gardening, occasional recreational activity
   - Moderate – regular (3x weekly) moderate activity, occasional weekend sports
   - Heavy – regular (4-6x weekly) vigorous activity and/or sports
   - Intense – Competitive vigorous sports training

   Describe _____

3. Do you ever have (during exertion or other times):
   - Discomfort/pressure in your chest, neck, jaw or arms YES NO
   - Lightheadedness, dizziness or fainting YES NO
   - Shortness of breath not associated with vigorous activity YES NO
   - Rapid heart beats YES NO

4. Do you smoke? YES If yes, how long have you smoked?_____Years
   NO If you used to smoke, when did you quit? _____

5. Have you ever been told by a doctor that you have:
   - High blood pressure YES NO DON'T KNOW
   - Diabetes YES NO DON'T KNOW
   - High cholesterol YES NO DON'T KNOW
   - Heart or lung problems YES NO DON'T KNOW

(continued)

6. Do you have a bone, joint or muscle problem that can be made worse by exercise? YES NO

   If yes, please describe _____

7. Are you pregnant? YES NO
8. Has your father, grandfather or brother had a heart attack or sudden death before the age of 55?
   YES NO
9. Has your mother, grandmother or sister had a heart attack or sudden death before the age of 65?
   YES NO
10. Please list all medications you currently take

    _____

    _____

    _____

11. Please list any other medical problems/health concerns

    _____

    _____

    _____

IF YOU RESPONDED "YES" TO 2 OR MORE ON QUESTIONS 2 – 9 ON THIS PRE-SCREENING FORM, WE REQUIRE THE ATTACHED PHYSICIAN ASSESSEMENT FORM TO BE COMPLETED BY YOUR PHYSICIAN PRIOR TO TESTING.

Signature_____Date _____

PHYSICIAN ASSESSMENT

Patient Name _____ Tel _____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

Physician Name	
Address	
Telephone	

Medications – Please list all medications currently taken by the patient

Name of Medication	Dose	How often

Physician Assessment

The patient named above is able to participate in exercise testing and exercise training. Exercise testing includes graded exercise testing on a treadmill or bike ergometer beginning at low level and gradually increasing to a maximal effort without ECG monitoring. Various tests may also be administered to assess muscular strength, flexibility, and body composition.

Exercise training may include cardiovascular exercise of varying intensities, strength training using various modalities, stretching, instructions in body mechanics and postural education.

- ❒ No Limitations
- ❒ Limitations as follows: _____

_____

_____

_____

Additional Physician recommendations, if any: _____

_____

_____

_____

Physician Signature		Date	