



Health Assessment Questionnaire

All information collected will be kept *confidential* by the Aztec Fitness staff and will not be viewed or shared with Gen-Probe. Please print all information.

This form must be completed prior to participating in the group exercise, massage therapy or personal training programs.

MEMBER INFORMATION

Name: _____ Date: _____
Phone (work): _____ DOB: _____
Title: _____ Department: _____
Email: _____
In case of emergency, contact (name & phone): _____
Physician name & phone: _____

EXERCISE HISTORY

Do you exercise regularly? _____ **IF YES**, for how long? ___years ___months
What type of activities/exercises do you participate in? _____
IF NO, how long has it been since you have regularly participated in an exercise program? ___years ___months
What were the reason(s) for discontinuing your exercise program? _____

ACTIVITY LEVEL: Consider your physical activity patterns during the past three (3) months. Circle the descriptive item below from each of the three categories below that best describes your average activity pattern for the past three months.

INTENSITY

1. Continuous light effort
2. Continuous moderate effort
3. Continuous moderately heavy effort
4. Intermittent vigorous effort
5. Continuous vigorous effort

DURATION

1. < 10 minutes
2. 10-20 minutes
3. 20-30 minutes
4. 30-60 minutes
5. > 60 minutes

FREQUENCY

1. < once per month
2. 1-4 times per month
3. 1-2 times per week
4. 3-5 times per week
5. > 5 times per week

HEALTH & FITNESS GOALS

1. _____
2. _____
3. _____

PRESENT HEALTH CONDITIONS

Please check the appropriate box of the condition(s) below that apply to you:

- | | |
|--|---|
| <input type="checkbox"/> Irregular hear rate or other arrhythmia <input type="checkbox"/> Obesity <input type="checkbox"/> Cancer <input type="checkbox"/> Stroke <input type="checkbox"/> Epilepsy/Seizures <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Fainting/Light-headedness <input type="checkbox"/> Ankle Swelling <input type="checkbox"/> Kidney disease <input type="checkbox"/> Thyroid or other metabolic disorders | <input type="checkbox"/> Lung or Pulmonary Condition <input type="checkbox"/> Asthma <input type="checkbox"/> Chronic bronchitis <input type="checkbox"/> Arthritis <input type="checkbox"/> Anemia <input type="checkbox"/> Fatigue (unexplained or unusual) <input type="checkbox"/> Other (please specify) _____ _____ _____ |
|--|---|

MEDICAL DATA – PRIMARY RISK FACTORS

1. Age: _____ 2. Gender: Male Female

Do you currently have any of the following conditions? (check all appropriate boxes)

DIAGNOSED HIGH BLOOD PRESSURE: $\geq 120/80$ mmHg, confirmed by measurements on at least 2 separate occasions, **OR** on Antihypertensive Medication. YES NO

DIAGNOSED HIGH CHOLESTEROL: Total Serum Cholesterol > 200 mg/dL **OR** HDL < 40 mg/dL YES NO

CURRENT CIGARETTE SMOKER: YES NO

FAMILY HISTORY: A heart attack or sudden death in father or other male first-degree relative before 55 years of age, **OR** in mother or other female first-degree relative before 65 years of age. YES NO

DIABETES MELLITUS: Insulin Dependent Diabetes Mellitus YES NO
OR Non-insulin Dependent Diabetes Mellitus
IF YES, how long have you had Diabetes? years months

SEDENTARY LIFESTYLE/PHYSICAL INACTIVITY: Do you currently sit for a large period of the day **AND** do not participate in regular exercise or active recreational pursuits? YES NO

MEDICAL DATA – SECONDARY RISK FACTORS

1. Have you experienced pain/discomfort (tightness) in the chest, neck, jaw, arms, or other areas at rest or with exertion? _____ **IF YES**, under what circumstances? _____
2. Do you have any back, joint, tendon, or muscular pain (shoulders, knees, hips, ankles, etc.)? _____
IF YES, please explain: _____
3. Have you had any surgeries in the past year that would affect exercise? _____ **IF YES**, please explain: _____
4. Please list any medications that you are taking:

| Name | Reason |
|-------|--------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
5. Have you ever been advised by a physician **NOT** to exercise? _____ **IF YES**, please describe: _____
6. Do you know of any other reason why you should not participate in regular physical activity? _____
IF YES, please explain: _____
7. Additional comments regarding medical or exercise history: _____

Nutritional Habits

1. How many meals do you have a day? _____
2. Do you have any food allergies? _____ If so, towards which food? _____
3. Do you drink alcohol? _____ If so, how many drinks per week? _____
4. When would you say is your biggest meal of the day? _____
5. Have you ever participated in a nutrition regimen/diet? _____ If so, which one? _____

I certify to the best of my knowledge that the above information is true and correct:

Signed: _____ Date: _____

Fitness Staff: _____

THANK YOU FOR TAKING THE TIME TO FILL OUT THIS QUESTIONNAIRE!



Release of Liability Waiver

Because physical exercise can be strenuous and subject to risk of serious injury, we urge you to obtain a physical examination from a doctor before using any exercise equipment or participating in any exercise activity. You agree that by participating in physical exercise, exercise therapy, you do so entirely at your own risk. Additional suggestions for food supplements are entirely your responsibility and you should consult a physician prior to undergoing any dietary or food supplement changes. You agree that you are voluntarily participating in these activities and assume all risks of injury, illness, or death.

You acknowledge that you have carefully read this "waiver and release" and fully understand it is a release of liability. You expressly agree to release and discharge the trainer or therapist from any and all claims or cause of action and you agree to voluntarily give up or waive any right that you may otherwise have to bring a legal action against the trainer or therapist for personal injury or property damage. To the extent that statute or case law does not prohibit releases for negligence, this release is also for negligence.

If any portion of this release from liability shall be deemed by a Court of competent jurisdiction to be invalid, then the remainder of this release from liability shall remain in full force and effect and the offending provision or provisions severed here from.

By signing the release, I acknowledge that I understand its content and that this release cannot be modified orally.

Participant Signature _____ Date: _____

Print Name _____

Signature of Aztec Fitness staff: _____ Date: _____

Payment and Cancellation Notice Agreement

I, _____ retain Aztec Fitness to render personal training, strength and conditioning, and exercise services for me. In exchange and consideration for such services, I agree to pay \$ _____ per appointment.

If I choose to prepay, an account will be set up I my name with Aztec Fitness. The amount indicated above will be deducted from my account after each appointment and I will receive an itemized invoice notifying me of payment when my account reaches zero.

Each of the indicated appointments shall be _____ minutes in duration.

I understand that I may cancel any appointment with my trainer by giving him or her 24 hours notice. I also understand that if I fail to provide the aforementioned cancellation notice, as indicated, I will be charged for the full session fee.

Signature _____ **Date** _____