



SEQUOIA PHYSICAL THERAPY HEALTH QUESTIONNAIRE

Date first enrolled _____ Date of questionnaire _____

Name _____ Age ____ Date of Birth _____

Address _____

City _____ State ____ Zip _____

Home Phone _____ Mobile Phone _____

Emergency Contact _____ Emergency Phone _____

Doctor _____ Phone _____

MEDICAL HISTORY: Referred to program by: self gym friend doctor
Please rate your current health: 0=worst and 10=best. Answer = _____

What is your height and weight? Height _____ Weight _____

Is your blood pressure? Low Normal High

Has your doctor ever told you to limit your physical activity? No Yes
If yes, why?

Has your doctor ever said you have a heart or lung condition? No Yes
If yes, please describe:

Do you feel pain in your chest when you exercise? No Yes

Do you have pain when you don't exercise? No Yes
If so, where?

Do you have neck pain? No Yes

Do you get dizzy? No Yes

Do you faint or lose consciousness? No Yes

Do you get short of breath when you exercise? No Yes

Do you have a history of asthma? No Yes

Do you have a history of cancer? No Yes

Do you have diabetes? No Yes
If so? Type 1 Type 2

Do you suffer from epilepsy? No Yes

Do you have any muscle, bone or joint problems? No Yes
If yes, which joints, bones or muscles give you pain?

Are there any other medical reasons not mentioned above that may prevent you from commencing a strength training program? No Yes

Have you fallen in the last 12 months? No Yes
If so, how many times? _____
Date of most recent fall _____

Do you have difficulty with stairs? No Yes

Are you currently on any medications? No Yes

Do you smoke? No Yes How many per day? _____
Would you like to quit? No Yes

What is the hardest activity of daily living that you are able to do at home (inside or outside your house)?

How long can you do it? _____ How often? _____

What other exercise have you been doing lately? _____

What intensity is that for you: 1) Hard _____ 2) Medium _____ 3) Light _____

How long can you do it for? _____ How often? _____

Please rate your current diet: 0=not healthy and 10=healthy. Answer = _____

How many servings of fruits do you eat daily? _____

How many servings of vegetables daily? _____

What are your health goals? _____

Participant's signature _____ **Date** _____