

J.R. SMITH COACHING, LLC
Medical History Questionnaire

Name: _____

Date of Birth: _____ Height: _____ Gender: _____ Weight _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

Physician: _____ Phone: _____

Emergency Contact: _____ Phone: _____

What is the present state of your health,
as you perceive it? _____

THE PHYSICAL ACTIVITY READINESS QUESTIONNAIRE:

Please answer yes or no to the following seven questions: **Explain any yes answers**

1. Has the doctor ever said that you have a heart condition and that you should only do physical activity recommended by a doctor? ___ yes ___no
2. Do you feel pain in your chest when you do physical activity? ___ yes ___no
3. In the past month, have you had chest pain when you were not doing physical activity? ___ yes ___no
4. Do you lose your balance because of dizziness or do you ever lose consciousness? ___ yes ___no
5. Do you have a bone or joint problem that could be made worse by a change in your physical activity? ___ yes ___no
6. Is your doctor currently prescribing medications for your blood pressure or heart condition? ___ yes ___no
7. Do you know of any other reason why you should not do physical activity? ___ yes ___no
8. Do you feel you are overweight ? ___yes ___no

Explanations: _____

Please answer the following questions:

Have you consulted your doctor prior to taking this test or engaging in this program ?

yes no **If yes, did your Dr. give you any limitations:** _____

Have you ever had any orthopedic problems (bone or joint)? yes no

If yes, please list: _____

Do you eat a balanced diet? yes no

If you are a woman, are you pregnant? yes no

Do you have a hernia or any other condition that may be aggravated by lifting weights?

yes no

Have you had surgery in the last 3 years? yes no

If yes, list surgeries and dates: _____

Are you taking any medications, drugs or supplements (vitamin, mineral or herbal)?

Intermittently or on a regular basis yes no

If yes, please list all medications

: _____

Please assess your cardiovascular health by marking yes or no to the following statements:

You are male over the age of 45 . yes no

You currently smoke. yes no

Your blood pressure is high (over 140/90 mmHg). yes no

Your total cholesterol is high (over 220 mg/dL). yes no

You have a family history of heart disease:

- Your father or other first degree male relative had a heart attack or sudden death before the age of 55; or
- Your mother or other first degree female relative had a heart attack or sudden death before the age of 65

yes no

Do you have diabetes. yes no

If yes, list medications: _____

You are physically inactive (sedentary job and no regular exercise). yes no

Do you have any of the following conditions? (circle all that apply):

Cardiovascular	Elevated blood pressure	Prior history of heart attack
	Heart murmur	Chest pain with exercise
	Rapid heart rate	Irregular heart beat
	Elevated cholesterol	Prior history of heart attack
	Prior history of heart surgery	
Pulmonary	Asthma	Coughing up blood
	Chronic cough	Exercise induced asthma
	Emphysema	COPD
	Bronchitis	Smoking history
Metabolic	Diabetes	Hypoglycemia
	Obesity	Thyroid disease
	Any type of endocrine disorder	
Musculoskeletal	Osteoporosis	Muscular atrophy
	Osteoarthritis	Low back pain
	Prosthesis	Artificial joints
Neurological	Seizure disorder	History of dizziness
	History of fainting	Sciatica
	Multiple Sclerosis	Extremity weakness

Please explain all circled conditions: _____

I have read this form carefully and answered each question honestly. I have taken note of the recommendations to see my physician prior to starting any exercise program.

Client Signature

Date

J.R. SMITH COACHING, LLC
Informed Consent

To assess cardiovascular function, body composition, and other physical fitness components, the undersigned hereby voluntarily consents to engage in a sub-maximal graded exercise test.

Explanation of the test: The graded exercise test is performed on a bicycle or ergometer or motor-driven treadmill. The workload is increased every minute until your heart rate is at V.T. (ventilatory threshold). Once within that zone, you will stay at a work rate slightly higher for approximately 2 minutes. You may stop the test at any time because of fatigue, discomfort or chest pain. This test assesses your cardiovascular/training fitness level.

Risks and discomforts: During the graded exercise test, certain changes may occur. These changes include abnormal blood pressure responses, fainting, irregularities in heartbeat and in rare instances, heart attack. Every effort is made to minimize these occurrences from happening.

Expected benefits from testing: These tests allow us to assess your physical working capacity and to appraise your physical fitness status. The results will be used to prescribe a safe, sound exercise program for you. Records are kept strictly confidential unless you consent to release this information. Initial assessment records are kept to track your progress.

Inquiries: Questions about the procedures used in the physical fitness test are encouraged. If you have any questions or need additional information, please ask us to explain further.

Freedom of consent: Your permission to perform this physical fitness test is strictly voluntary. You are free to stop the test at any point if you so desire.

I have read this form carefully and I fully understand the test procedure that I will perform and the risks and discomforts. Knowing these risks and having had the opportunity to ask questions that have been answered to my satisfaction, I consent to participate in this test.

Signature

Date

Printed Name

Tester's/Coach's Initials