PROVIDENCE WELLNESS CENTER

1200 Providence Road
Wayne, NE 68787

PRE-PARTICIPATION SCREENING QUESTIONNAIRE

Date: _____

1. Name: _____
(Last) (First) (Middle I.)

2. Address: _____
(Street/RR./Box) City Zip

3. Telephone #: _____

4. If joining under a corporate membership, which company?

_____

5. Sex: M____ F____

6. Birth date: _____/_____/_____

7. Age: _____

8. Height: _____

9. Weight: _____

10. Assess your health needs by marking all *true* statements:

History

You have had:
___ a heart attack
___ heart surgery
___cardiac catheterization
___coronary angioplasty (PTCA)
___pacemaker/implantable cardiac
Defibrillator/rhythm disturbance
___heart valve disease
___heart failure
___heart transplantation

**If you marked any of the statements in this section consult your healthcare provider before engaging in exercise*

Other health issues:

Symptoms

____ You experience chest discomfort with exertion.
____ You experience unreasonable breathlessness.
____ You experience dizziness, fainting, blackouts.
____ You have musculoskeletal problems
____ You have concerns about the safety of exercise
____ You take prescription medication(s).
____ You are pregnant.
____ You take heart medications.

Cardiovascular risk factors:

____ You are a man older than 45 years.
____ You are a woman older than 55 years or you have had a hysterectomy or you are postmenopausal.
____ You smoke.
____ Your blood pressure is greater than 140/90.
____ You don't know your blood pressure.
____ You take blood pressure medication.
____ Your blood cholesterol level is >240 mg/dL.
____ You don't know your cholesterol level.
____ You have a close blood relative that had a heart attack before age 55 (father or brother) or age 65 (mother or sister).
____ You are diabetic or take medicine to control your blood sugar.
____ You are physically inactive (i.e., you get less than 30 minutes of physical activity on at least 3 days per week.
____ You are more than 20 pounds overweight.

If you marked two or more of the statements in this section, you should consult your healthcare provider before engaging in exercise.

____ None of the above is true.

You should be able to exercise safely without consulting your healthcare provider.

11. Please list any medications that you use:

12. Have you been diagnosed with Osteoporosis? Y_____ / N_____.

13. What goals do you want to accomplish when starting this exercise program?

14. Tell us how you found out about us:

STAFF USE ONLY

Resting Heart Rate: _____bpm

Resting Blood Pressure: _____mmHg

Cleared to Exercise: Y/ N

Reason:_____
_____
_____

Requests an Equipment Orientation: Y / N **Date: _____**

Requests a Personal Training Consultation: Y / N **Date: _____**

Staff Member _____ **Date**: _____/_____/_____