Pre-Activity Questionnaire

SENTARA
RMH Wellness Center

Appointment Reminder

Fitness Assessment: **Date**_____ **Time**_____ **Staff**_____

A ***Fitness Assessment*** will asses your current body composition, muscular strength, muscular endurance, muscular flexibility and cardiorespiratory fitness.

- Come dressed to exercise (long sleeve shirts and pants are not recommended).
- Avoid food, alcohol, tobacco, and caffeine for 3 hours prior to the test.
- Come well-rested and avoid strenuous exercise on the day prior to your Fitness Assessment

Exercise recommendations will be based on results from your assessment and your goals. A staff member will then develop an exercise prescription to help you meet your goals.

Exercise Prescription will be scheduled after completing your fitness assessment.

Please give 24 hours notice to cancel your appointment (540) 564-5682.

Personal Information ***(please fill out in advance and bring to your assessment appointment)***

Name: _____ Age: _____

1. What are your current fitness goals? _____

   _____
2. How long have you had the above goals? _____
3. How important is it that you reach these goals? _____
4. What has prevented you from reaching these goals in the past? _____

   _____
5. The American College of Sports Medicine recommends activity levels of 30 minutes per day moderate cardio, 5 days a week or 20 minutes per day vigorous cardio, 3 days a week. Are your currently meeting these guidelines? Yes/ No
6. The American College of Sports Medicine recommends 8-10 strength training exercises with 8-12 repetitions, 2 times a week. Are you currently meeting these guidelines? Yes/ No
7. What is your current occupation? _____

   _____
8. Does your occupation require extended periods of sitting? Yes / No
9. Does your occupation require repetitive movement? (If yes, please explain.)

   _____

   _____
10. Does your occupation require you to wear shoes with a heel (dress shoes)? Yes / No
11. Does your occupation cause you anxiety (mental stress), (If yes, please explain.)_____

    _____
12. Do you partake in any recreational activities (golf, tennis, skiing, etc.)? (If yes, please explain.)

    _____

13. Do you have any hobbies (reading, gardening, working on cars, etc.)? (If yes, please explain.)

_____

_____

Current or Previous Injuries and or Illnesses

14. Do you currently have any pain or injuries (ankle, knee, hip, back, shoulder, etc.)?

_____

_____

15. Have you ever had any pain or injuries (ankle, knee, hip, back, shoulder, etc.)? If so please state when. _____

_____

16. Have you ever had any surgeries? (If yes, please explain)_____

_____

_____

Medical History

1. Are you currently taking any medication? (If yes, please list.)_____

_____

_____

2. Have you been diagnosed as having any of the following conditions? Please circle all that apply.

Anemia	Diabetes	Kidney disease	Stroke
Asthma	Thyroid problem	HIV / AIDS	Heart disease
High Cholesterol	Emphysema	Lupus	Pregnancy
Cancer	Epilepsy	Post Polio Syndrome	Fibromyalgia
Heart attack	Low blood pressure	Multiple Sclerosis	Neurological disorder
Eating disorder	High blood pressure	Arthritic conditions	
Circulatory problems	Rheumatoid Arthritis	Pulmonary disease	
Depression	Hepatitis	Parkinson's	

3. Do you have any allergies? _____

_____

ASSESSOR'S COMMENTS

_____

_____

_____

_____

Please fill out in advance and bring to your assessment appointment