CULPEPER SPORT & FITNESS
POWELL WELLNESS CENTER
Culpeper Wellness Foundation

STAFF USE ONLY

Assessment Appt: _____/_____ @ _____

Orientation Appt: _____/_____ @ _____

Notes: _____

HEALTH HISTORY QUESTIONNAIRE

Last Name	First Name	M.I.	Email Address

Birth Date	Age	Height	Weight	Sex M/F

FitScripts only

Primary Physician Name/Specialty	Physician Practice	Phone Number	Fax Number

Did the above physician refer you to Powell Wellness Center, LLC? **YES** **NO**

If no, please indicate the medical professional who referred you to Powell Wellness Center, LLC?

Name: _____ **Phone Number:** _____ **Fax:** _____

A. PLEASE CHECK YES OR NO:

(If answered yes to any questions in Section A, please obtain medical clearance)

Do you have chest pain brought on by physical activity?	❑Yes	❑No
Do you experience unreasonable breathlessness?	❑Yes	❑No
Have you developed chest pain in the past month?	❑Yes	❑No
Have you on one or more occasions lost consciousness or fallen over as a result of dizziness?	❑Yes	❑No
Have you ever injured a bone, joint, or muscle due to a fall or loss of consciousness?	❑Yes	❑No
Is your physician currently prescribing medications for a blood pressure or heart condition?	❑Yes	❑No

B. PLEASE CHECK ALL THAT APPLY TO YOU OR THAT YOU HAVE BEEN DIAGNOSED WITH:

(Please obtain medical clearance if two or more risk factors are checked in Section B)

- ❑ Age: >45 (male), >55 (female)
- ❑ Family History of Heart Disease *(under age 55 for male relative, or 65 years for female relative)*
- ❑ Current Cigarette Smoking *(or quit in the last 6 months)*
- ❑ High Blood Pressure- greater than 140/90 mmHg, or on antihypertensive medications, and/or blood pressure unknown
- ❑ Hypercholesterolemia: *(or if cholesterol is unknown)*
  - *Total Cholesterol >200mg/dl*
  - *LDL Cholesterol>130 mg/dl*
  - *HDL <40 mg/dl*
- ❑ Impaired Fasting Glucose: Fasting blood glucose greater than or equal to 100 mg/dl
- ❑ Obesity: Body Mass Index > 30 or waist circumference > 40 (men), and >35 (women)
- ❑ Sedentary Lifestyle/Physical Inactivity *(accumulate less 30 minutes per day)*

C. PLEASE CHECK ALL THAT APPLY OR THAT YOU HAVE BEEN DIAGNOSED WITH:

(Please obtain medical clearance if one or more boxes are checked in Section C)

- ❑ Heart Disease/Stroke/Heart Attack
- ❑ Chest Pain/Angina
- ❑ Abnormal EKG
- ❑ Heart Murmur/ Heart Valve Disorder
- ❑ Rapid Heart Rate/ Arrhythmia
- ❑ Emphysema
- ❑ Alzheimer's Disease
- ❑ Cerebral Palsy
- ❑ Multiple Sclerosis
- ❑ Parkinson's Disease
- ❑ Epilepsy/Seizures
- ❑ Claudication/Peripheral Vascular Disease
- ❑ Lung/Pulmonary Disease
- ❑ Cystic Fibrosis
- ❑ Asthma - Exercise Induced Only *(not seasonal)*
- ❑ Congestive Heart Failure
- ❑ Diabetes Mellitus Type 1 or Type 2
- ❑ Arthritis *(Rheumatoid only)*
- ❑ Joint/Muscle Disorder
- ❑ Back Injury/Surgery
- ❑ Fibromyalgia
- ❑ Herniated Disk
- ❑ Lupus
- ❑ Mental/Nervous Disorder

If needed, please explain any 'Yes' answers in the space below:

_____

Do you have any other conditions, diseases, orthopedic conditions or limitations? ❑Yes ❑No

_____

In the past 10 years have you experienced any major illnesses, hospitalization, or surgery that may affect your ability to participate in physical activity? Explain below, if needed. ❑Yes ❑No

_____

D. EXERCISE HISTORY

Do you perform any exercise or purposeful physical activity: ❑Yes ❑ No **If yes, list the activity and duration below:**

_____ _____/_____

_____ _____/_____

E. WAIVER AND THE ASSUMPTION OF THE RISK

I hereby release and forever discharge and hold harmless Culpeper Wellness Foundation and/or Powell Wellness Center, LLC, their successors, assigns and third-party agents, from any and all liability, claims and demands of any nature, either in law or equity, which may arise from any and all of the physical activity I may engage in while on the premises operated by Powell Wellness Center, LLC. In addition thereto, I fully comprehend that there exists an inherent risk and physical and other injuries, including death, associated with engaging in physical activity. I am knowingly assuming any and all of such harm that may occur to me while on the premises operated by Powell Wellness Center, LLC. Finally, I in no way hold Powell Wellness Center, LLC responsible for knowing my medical condition as it relates to my ability to withstand physical activity as recorded on this Health History Questionnaire.

F. EXCHANGE OF MEDICAL INFORMATION – *FitScripts only*

I authorize the exchange of any relevant medical or health related information between Powell Wellness Center, LLC and the physician I have previously designated. I understand this consent can be revoked at any time except to the extent that disclosure made in good faith had already occurred in reliance of this consent.

Signature: _____ Date: _____

I have read, understood, and completed this questionnaire to the best of my ability, and as accurately and completely as possible. Any questions that I had were answered to my full satisfaction. This information is confidential and only intended for use by the appropriate employees of Culpeper Wellness Foundation and/or Powell Wellness Center, LLC.

Signature: _____ Date: _____