



Health History Questionnaire/Informed Consent Form

Last Name _____ First Name _____ M.I. _____
 Date of Birth ____/____/____ Sex: M F
 Address _____
 City _____ State _____ Zip Code _____
 Home Phone _____ Work Phone _____ Ext. _____
 Email Address _____ Mobile _____
 Occupation _____
 Primary Physician _____ Address _____
 Phone _____
 Who should be contacted in case of an emergency?
 Name _____ Phone _____
 How did you hear about Body-N-Motion? _____

Medical Evaluation

When was the last time you had a physical examination? ____/____/____
 By whom was the exam performed? _____
 Have you ever been diagnosed with any chronic or serious illness? _____
 If yes, please explain. _____

Have you ever experienced any reoccurring pain in any joints or muscles? _____
 If yes, please explain. _____

Please list any medications that you are currently taking and please include the conditions for which they were prescribed: _____

If you have ever been hospitalized for any reason or had and major surgeries, please provide any information about your condition or any procedure that was performed.. _____

During the past 12 months...

Has your weight fluctuated more than five pounds?	Yes	No
Did you attempt to bring this change through diet and exercise?	Yes	No
Have you ever experienced any faintness, light-headedness, or blackouts?	Yes	No
Have you occasionally had trouble sleeping?	Yes	No
Have you experienced blurred vision?	Yes	No
Have you had any severe headaches?	Yes	No
Have you experienced a chronic morning cough?	Yes	No

Have you experienced any temporary change in your speech pattern, such as slurring or loss of speech?	Yes	No
Have you felt unusually nervous or anxious for no apparent reason?	Yes	No
Have you experienced periods in which your heart felt as though it was racing for no apparent reason?	Yes	No
Have you experienced any feeling of tightness or constriction in your chest?	Yes	No
Have you experienced any shortness of breath while performing daily activities?	Yes	No
Have you noticed that your hands and/or feet sometimes feel cooler than the rest of your body?	Yes	No
Do you experience swelling in your feet and ankles?	Yes	No
Have you ever been told that your serum cholesterol or triglyceride level was too high?	Yes	No
Have you been diagnosed with diabetes?	Yes	No
If yes, when were you diagnosed? _____/_____/_____		
If yes, how is it controlled? _____		

Has any member of your family been treated or suspected to have any of the following conditions?

Diabetes_____	Relationship_____
Heart Disease_____	Relationship_____
Stroke_____	Relationship_____
Hypertension_____	Relationship_____

Exercise/Lifestyle Evaluation

Do you currently exercise vigorously on a regular basis? Yes No

What activities do you engage in on a regular basis?

Running/Jogging_____	Fitness Walking_____	Swimming_____
Weight Training_____	Aerobics_____	Tennis_____
Racquetball_____	In-line Skating_____	Bicycling_____
Rowing_____	Other_____	

What is the average duration of each of your workouts (in minutes)? 30 45 60 75 90+

How many workouts do you participate in each week? 1 2 3 4 5 6 7 or more

Is your occupation: Inactive (e.g. desk job)_____

Light Work (e.g. housework, distribution)_____

Heavy Work (e.g. heavy carpentry, masonry)_____

What is your current weight?_____ height?_____

What would you like to weigh?_____

What is the most you have ever weighed as an adult?_____

What is the least you have ever weighed as an adult?_____

What weight loss methods have you tried in the past?_____

What would you like to change about your physique?_____

What are the major drawbacks in regard to your lifestyle that inhibit your participation in a program of regular exercise? _____

What are the major drawbacks regarding your dietary habits that inhibit your consumption of a healthy, balanced diet? _____

Do you eat breakfast on a regular basis? Yes No

Do you eat lunch on a regular basis? Yes No

Do you eat dinner on a regular basis? Yes No

Do you skip meals on a regular basis? Yes No

Do you eat snacks on a regular basis? Yes No

Include a short list of items you frequently consume between meals: _____

Cite some examples of food you intake on an average day:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

What size portions do you normally consume?

Small _____ Medium _____ Large _____

Do you usually eat dinner after 7 p.m.? Yes No

Do you usually eat anything 2-3 hours before bedtime? Yes No

Do you presently smoke cigarettes, cigars, or a pipe? Yes No

Have you ever smoked during any period in your lifetime? Yes No

If yes, how long did you smoke? _____

If you have successfully quit, when did you quit? _____

During the past month, how many days did you drink alcoholic beverages? _____

During the past month, how many times did you drink more than 5 drinks per occasion? _____

WAIVER, RELEASE AND HOLD HARMLESS

Body-N-Motion (BNM), recommends that I consult with my personal physician as to the nature and extent of any activity in which I may participate. I have either so consulted or elected not to consult with my personal physician. My participation in any activity and the use of your equipment is voluntary. I assume any responsibility and risk of personal injury arising out of or with respect to my participation in any activity and the use of BNM equipment. Moreover, BNM and its employees and contractors are not responsible for damage to or the loss of my personal property.

Based upon the foregoing, I waive any right I have or may acquire against, BNM, its employees and contractors, and release, discharge and agree to indemnify BNM, any employee, agent, consultant or independent contractor of theirs, and their respective successors or assigns, from or in respect of any claim, demand, cause of action, known or unknown, anticipated or unanticipated, resulting from any activity, or any of your equipment, and any damage to my personal property.

Name (printed) _____

Signature _____

Date _____