



Subjective Information



Name _____

Date _____

Address _____

Phone _____

GENERAL AND MEDICAL QUESTIONNAIRE

Occupational Questions		Yes	No
1	What is your current occupation? _____		
2	Does your occupation require extended periods of sitting?		
3	Does your occupation require extended periods of repetitive movements? (If yes, please explain.) _____		
4	Does your occupation require you to wear shoes with a heel (dress shoes)?		
5	Does your occupation cause you anxiety (mental stress)?		
Recreational Questions		Yes	No
6	Do you partake in any recreational activities (golf, tennis, skiing, etc.)? (If yes, please explain.) _____ _____		
7	Do you have any hobbies (reading, gardening, working on cars, exploring the Internet, etc.)? (If yes, please explain.) _____ _____		
8	What are your exercise program goals? _____ _____		
9	What types of exercise interest you? _____ _____		
Medical Questions		Yes	No
10	Have you ever had any pain or injuries (ankle, knee, hip, back, shoulder, etc.)? (If yes, please explain.) _____ _____		
11	Have you ever had any surgeries? (If yes, please explain.) _____ _____		
12	Has a medical doctor ever diagnosed you with a chronic disease, such as coronary heart disease, coronary artery disease, hypertension (high blood pressure), high cholesterol or diabetes? (If yes, please explain.) _____ _____		
13	Are you currently taking any medication? (If yes, please list.) _____ _____ _____		