True Health Center

Participant Activity Readiness Questionnaire

FORM 2

Last Name: First Name Date: Chart#		
Date of Birth: Age Gender (M) (F) Email:		
Has a doctor ever said you have a heart condition?	Y	N
Has a doctor ever limited your physical activity? Gave you recommendations to limit activity?	Y	N
Do you feel pain in your chest when you do physical activity?	Y	N
In the past month, have you had chest pain when you are not doing physical activity?	Y	N
Do you or have you lost your balance because of dizziness, or loss consciousness?	Y	N
Is your doctor currently prescribing drugs for blood pressure or heart conditions?	Y	N
Do you have a bone, joint, or muscular issue that could be made worse by a change in physical activity?	Y	N
Do you have COPD, Uncontrolled Asthma, Chronic Bronchitis, or any other Respiratory issue?	Y	N
If on medications, do any affect your heart rate?	Y	N
Do you have or have had ankle / feet swelling?	Y	N
Are you on Beta Blockers for your heart / blood pressure	Y	N
Have you been or are you now anemic?	Y	N
Are You Pregnant?	Y	N

Medications - Please List Medications or Provide Us with a List to Copy

Medication Name	Dosage	Purpose of Medication

☐ If you have any questions about your heart, or medications affecting your heart, please consult your doctor before proceeding with any physical testing.

☐ I have reviewed these questions and answered them to the best of my ability. I understand that these materials will be reviewed and I may be asked to see my doctor before participating.

☐ I also give permission for my testing information to be used in studies, publications, and community awareness materials on the importance of Fitness and Health, understanding that my personal information will be removed and not published in any format unless I give specific permission in writing.

_____ _____

Signature Date