COLUMBUS STATE
COLLEGE RECREATION AND WELLNESS

Health Questionnaire

American Heart Association / American College of Sports Medicine
Health and Fitness Facility Pre-participation Screening Questionnaire

Name: _____

Assess your health status by initialing all true statements:

HISTORY
You have had:

_____a heart attack or heart failure
_____heart surgery
_____metabolic disease
_____pacemaker or other heart device
_____heart valve or congenital heart disease
_____pulmonary disease
_____stroke
_____coronary artery disease
_____currently pregnant
_____musculoskeletal/nerve problems

If you marked any of these statements in this section, consult your physician or other appropriate health care provider before engaging in exercise. You may need to use a facility with a medically qualified staff.

SYMPTOMS

_____Pain in chest, neck, jaw or arms
_____Shortness of breath with mild exertion
_____Palpitations, Tachycardia or irregular heart beat
_____Orthopenea or Paroxsomal Nocturnal Dyspnea
_____Intermittent Claudication/Thrombosis
_____Ankle Swelling
_____Heart Murmur
_____Dizziness

RISKFACTORS

_____You are a man older than 45 years
_____You are a woman older than 55 years, have had a hysterectomy, or are postmenopausal.
_____You smoke, or quit smoking within the previous 6 months.
_____Your blood pressure is >140/90mmHg.
_____You do not know your blood pressure.
_____You take blood pressure medication.
_____Your blood cholesterol level is >200mg/dl.
_____You do not know your cholesterol level.

If you marked 2 or more in this section you should consult your physician or appropriate health care provider before engaging in exercise. You might benefit from using a facility with a professionally qualified exercise staff to guide your exercise.

_____You have a close blood relative who had a heart attack or heart surgery before the age 55 male or 65 female.
_____You are physically inactive (i.e., you get <30min of physical activity at least 3 days per week)
_____You are greater than 20 pounds overweight
_____You are diabetic or take medication to control blood sugar
_____You take prescription medication

_____None of the above

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College Recreation & Wellness PAR-Q and Consent form

Name_____ ID_____ Email_____
Date of Birth_____/_____/_____ Height_____ Gender_____
Emergency Contact Name and Number_____

1. Has a physician ever told you that you have heart trouble?	Yes	No
2. Do you frequently have pains in the heart and chest?	Yes	No
3. Do you often feel faint or have spells of severe dizziness?	Yes	No
4. Has a physician ever told you that your blood pressure was too high?	Yes	No
5. Has a physician ever told you that you have a bone or joint problem such as arthritis that has been aggravated or might be made worse by exercise?	Yes	No
6. Do you have a good physical reason not mentioned here why you should not follow an activity program even if you wanted to?	Yes	No
7. Are you over the age of 65 and not accustomed to vigorous exercise?	Yes	No

Notes_____

Client Consent Form

EXERCISE TESTING CONSENT

You will be participating in a variety of fitness tests based on your current level of activity. These tests include, but are not limited to: 3 min. step-test, pushups to fatigue, and sit-ups. The CRW staff may stop the test at any time if signs of fatigue, or changes in your heart rate or blood pressure occur. It is important for you to realize that you may stop when you wish because of feelings of fatigue or any other discomfort.

ATTENDANT RISKS AND DISCOMFORTS

There exists the possibility of certain changes occurring during the test. They include abnormal blood pressure, dizziness, fainting, irregular, fast or slow heart rhythm, and in rare cases heart attack, stroke or death. All efforts will be made to minimize these risks by evaluation of preliminary information relating to your health and fitness and by observations during testing.

PHYSICIAN'S RELEASE REQUEST

A physician's release may be requested by the Department of College Recreation & Wellness at any time. In order to be a personal training client a physician's release submitted to the Department of College Recreation & Wellness.

RESPONSIBILITIES OF THE PARTICIPANT

You are responsible for disclosing pertinent medical history information about your health status, as well as promptly reporting any abnormal feelings of discomfort to the CRW staff.

FREEDOM OF CONSENT

Your permission to perform this exercise test is voluntary and you are free to stop the test at any point, if you desire.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have been provided a copy of the notice of privacy practices of the Department of College Recreation & Wellness Center of the Columbus State Community College and I have been given a chance to read it and ask questions. I hereby agree to the policies outlined in the Notice of Privacy Practices. I hereby agree in writing to allow the Department of College Recreation & Wellness to use and disclose my health information for the reasons disclosed in section 1 of the Notice of Privacy Practices. I have read this form, and understand the test procedures and the attendant risks and discomforts. Knowing these risks and discomforts, and having had an opportunity to ask questions that have been answered to my satisfaction, I consent to participate in this test

Client Name **Date**

CRW Staff Signature **Date**

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Please answer the following questions:

What classes are you interested in taking?

What is your current fitness routine? How many days a week are you active and what types of exercise/activities?

What are your health and fitness goals?