



SHAPE HEALTH HISTORY QUESTIONNAIRE

Client ID# _____

Date _____

Part I. Personal Information

Name(Last, First, Middle):				
Mailing Address:		City:	State:	Zip:
Home Phone:	Work Phone:	Cell Phone:	Best Time Be Contacted:	
Email:				
Emergency Contact:		Relationship:	Phone:	



SHAPE HEALTH HISTORY QUESTIONNAIRE

Client ID # ___

Date _____

Trainer _____

Site _____

Part I. Personal Information (continued)

Birth Date(MM/DD/YY):	Age:	Rank:	Gender (Circle one): Male / Female
CFL/OIC Name (Authorized person that may request information regarding PT status):			Phone:

Part II. Exercise/Physical Activity History

1. List 3 goals that you want to achieve

- a. _____
- b. _____
- c. _____

2. What do you want exercise to do for you? Please rate the importance of each item from the scale listed below.

Extremely Important	Somewhat Important	Not at all Important
1 2 3 4	5 6 7 8	9 10
___ Improve cardiovascular fitness	___ Improve performance for a specific sport	
___ Weight loss	___ Ability to cope with stress	
___ Improve muscle definition	___ Improve flexibility	
___ Increase strength	___ Increase energy level	
___ Feel better	___ Improve daily functioning	
___ Improve performance on the PRT/PFT/CFT	___ improve overall health and wellness	

3. What is your perception of your current body age? (Circle one)

25-26yrs	27-28yrs	29-30yrs	31-32yrs	33-34yrs	35-36yrs	37-38yrs	39-40yrs	41-42yrs	43-44yrs
45-46yrs	47-48yrs	49-50yrs	51-52yrs	53-54yrs	55-56yrs	57-58yrs	59-60yrs	61-62yrs	63-64yrs

4. Are you currently involved in an exercise program? Yes No

If yes, please fill out the following chart.

Day of the Week	Cardio Exercise (Minutes)	Strength (Minutes)	Flexibility (Minutes)
Monday			
Tuesday			
Wednesday			
Thursday			
Friday			
Saturday			
Sunday			

Part III. Medical History

A. Please answer the following questions:

YES NO

- 1. Has your doctor ever said that you have a heart condition and that you should only do physical activity recommended by a doctor?
- 2. Do you feel pain in your chest when you do physical activity?
- 3. In the past month, have you had chest pain when you were not doing physical activity?
- 4. Do you lose your balance because of dizziness or do you ever lose consciousness?
- 5. Do you have a bone or joint problem that could be made worse by a change in your physical activity?
- 6. Is your doctor currently prescribing drugs (for example, water pills) for your blood pressure or heart condition?
- 7. Do you know of any other reason why you should not do physical activity?

B. Check the appropriate answer:

YES NO

- 1. Have you been diagnosed with high blood pressure?
If yes, are you taking medication? No Yes
- 2. Is there a family history (before the age of 55) of heart problems, or sudden death due to a heart problem?
If yes, circle all that apply: Mother Father Sister Brother
- 3. Do you have a total cholesterol value of greater than 200 ml/Dl?
If yes, HDL___ **LDL** ___
- 4. Do you experience shortness of breath at rest or with mild exertion?
- 5. Have you used tobacco products?
If yes, how long: _____ **How much/often:** _____ **If you quit, date of when you quit:** _____
- 6. Do you have Diabetes?
If yes, date diagnosed? _____ **Type?** _____

Women only

- 7. Are you currently pregnant?
If yes, _____ **weeks.** **Any complications with current pregnancy?** _____

C. Please **circle** any of the following for which you have been diagnosed or currently being treated by a physician or health professional:

- | | | | |
|---------------|----------------------|----------------------|---------------------------|
| Asthma | Concussion | Hypoglycemia | Intermittent Claudication |
| Epilepsy | Thyroid problem | Obesity | Palpitations |
| Heart problem | Emphysema | Bronchitis (chronic) | Orthopnea |
| Stroke | Rheumatoid arthritis | Dys/amenorrhea | Tachycardia |
| Arthritis | Anemia | Heat Stroke | OTHER: _____ |

D. **List** all medications and/or supplements you are currently taking:

Name of Medication or supplement	Reason	Dosage	Frequency

E. **Circle** any injury (recent or old) that still causes you pain or discomfort from time to time:

Arm Shoulder Knee Low back Neck
 Ankle Elbow Wrist Other _____

F. **Circle** the amount of time you spend sitting during the course of most days of the week:

- a. Almost none of the time
- b. Approximately ¼ of the time
- c. Approximately ½ of the time
- d. Approximately ¾ of the time
- e. Almost all the time

G. **Circle** the response which most accurately answers the following questions:
 How likely are you to doze off or fall asleep in the following situations?

- | | |
|--|---|
| 1. Sitting and Reading | Never - Slight chance - Moderate chance - High chance |
| 2. Watching TV | Never - Slight chance - Moderate chance - High chance |
| 3. Sitting, inactive in a public place
(e.g., a theater or a meeting) | Never - Slight chance - Moderate chance - High chance |
| 4. As a passenger in a car for an hour without
a break | Never - Slight chance - Moderate chance - High chance |
| 5. Lying down to rest in the afternoon when
circumstances permit | Never - Slight chance - Moderate chance - High chance |
| 6. Sitting and talking to someone | Never - Slight chance - Moderate chance - High chance |
| 7. Sitting quietly after a lunch without alcohol | Never - Slight chance - Moderate chance - High chance |
| 8. In a car, while stopped for a few minutes in
the traffic | Never - Slight chance - Moderate chance - High chance |

H. **Circle** the response which represents how strongly you agree or disagree with the following questions:

During the past week I've found that	Disagree							Agree
1. My motivation is lower when I am fatigued.	1	2	3	4	5	6	7	
2. Exercise brings on my fatigue.	1	2	3	4	5	6	7	
3. I am easily fatigued.	1	2	3	4	5	6	7	
4. Fatigue interferes with my physical functioning.	1	2	3	4	5	6	7	
5. Fatigue causes frequent problems for me.	1	2	3	4	5	6	7	
6. My fatigue prevents sustained physical functioning.	1	2	3	4	5	6	7	
7. Fatigue interferes with carrying out certain duties and responsibilities.	1	2	3	4	5	6	7	
8. Fatigue is among my three most disabling symptoms.	1	2	3	4	5	6	7	
9. Fatigue interferes with my work, family, or social life.	1	2	3	4	5	6	7	

Active Duty Only

Circle one: **USN** **USMC** **USA** **USAF** **USCG**

1. What does your unit PT schedule consist of?

	Activity	duration	difficulty level (easy/moderate/hard)
Monday	_____	_____	_____
Tuesday	_____	_____	_____
Wednesday	_____	_____	_____
Thursday	_____	_____	_____
Friday	_____	_____	_____

2. Date of your last PRT / PFT: _____ Date of your next PRT / PFT: _____

<u>PFT SCORE</u>	<u>PRT SCORE</u>	<u>Other Military Service Test</u>
Pull-ups _____	Push-ups _____	_____
Chin-ups _____	Run time _____	_____
Flex-arm-hang _____	Swim time _____	_____
Crunches _____	Curl ups _____	_____
Run time _____	Sit and Reach P/F _____	_____
Score: _____	Score: _____	Score: _____

3. Goals for your next PRT / PFT _____

4. Do you want this addressed in your program? No Yes

5. Are you on light or limited duty? No Yes *Light duty chit and MD release will be required prior to initial appointment.*

Trainers comments: _____

6. Are you currently assigned to FEP? No Yes Are you on the Body Comp Program (BCP)? No Yes

Reason? _____

Name of CFL/SNCO in charge of physical training _____ Phone # _____

7. What is the FEP training schedule:

Days/activity/duration/difficulty level	
Monday _____	Friday _____
Tuesday _____	Saturday _____
Wednesday _____	Sunday _____
Thursday _____	

8. Do you have any additional required PT during the week?

No Yes Explain _____

9. Will this exercise program replace the current FEP PT? No Yes