KÔR
Health/Medical Questionaire

Date: _____

Name: _____ Date of Birth: _____

Address: _____
Street City State Zip

Phone (H): _____ (W): _____ (C): _____

E-mail address: _____

In case of emergency, whom may we contact?

Name: _____ Relationship: _____

Phone (H): _____ (W or C): _____

Personal Physician

Name: _____ Phone:_____ Fax: _____

Present/Past History
Have you **had** or do you presently **have** any of the following conditions? (Check if ***yes***)

___ Rheumatic fever
___ Recent operation
___ Edema (swelling of ankles)
___ High blood pressure
___ Injury to back or knees
___ Low blood pressure
___ Seizures
___ Lung disease
___ Heart attack
___ Fainting of dizziness
___ Diabetes
___ High cholesterol
___ Shortness of breath at rest or with mild exertion
___ Chest pains
___ Palpitations or tachycardia (unusually strong or rapid heartbeat)
___ Pain, discomfort in the chest, neck, jaw, arms, or other areas
___ Known heart murmur
___ Unusual fatigue or shortness of breath with usual activities
___ Temporary loss of visual acuity or speech, or short-term numbness or weakness in one side, arm, or leg of your body
___ Other

Family History

Have any of your first-degree relatives (parent, sibling, or child) experienced the following conditions? (Check if *yes*.) In addition, please identify at what age the condition occurred.

___ Heart attack
___ Heart operation
___ Congenital heart disease
___ High blood pressure
___ High cholesterol
___ Diabetes
___ Other major illness _____

Activity History

1. How were you referred to KÔR? _____

2. What are your goals at KÔR? _____

3. Have you ever worked with a personal trainer or Pilates instructor before? Yes _____ No ___

4. Date of your last physical examination performed by a physician: _____

5. Do you participate in a regular exercise program at this time? Yes ___ No ___ If yes, briefly describe:

6. Have you ever performed resistance training or Pilates in the past? Yes _____ No ____

7. Do you have any injuries/disabilities that may interfere with exercising? Yes _ No ____ If yes, briefly describe: _____

8. Do you smoke? Yes _____ No _____

9. Do you follow any specific dietary plan, and in general, how do you feel about your nutritional habits? __

10. List the medications you are presently taking._____

11. List in order your personal health/fitness objectives, if any.
    a. _____
    b. _____
    c. _____