



In an effort to keep your exercise experience safe, Acceleration Sports Institute has developed this questionnaire because many conditions and medications can affect your health while exercising. We recommend you check with your physician before starting any exercise program. Your responses will be treated in a confidential manner. Please answer the following questions as accurately as you can.

Please Print Clearly

Name (First) _____ (Last) _____

Date of Birth ____/____/____ Age ____ Sex ____ Height _____ Weight _____

Address _____ Phone (home): (____) _____

City/State/Zip Code _____ Cell Phone: (____) _____

Email address _____

EMERGENCY CONTACT

Name: _____ Home Phone: (____) _____

Relationship: _____ Cell Phone: (____) _____

MEDICAL INFORMATION

Doctor's name _____ Phone (____) _____

Date of last physical ____/____/____ Date of Stress Test (if done) ____/____/____

In General, would you say your health is: **Excellent** **Very Good** **Good** **Fair** **Poor**

Past year physical activity history (*select best answer*)

- A. Inactive
- B. Light physical activity, less than 1 hour per week
- C. Moderate physical activity, more than 1 hour per week
- D. Vigorous physical activity
- E. Both C & D above

Physical activities I enjoy are _____

My health goal(s) is/are _____

MEDICATIONS: Dosage & how often (list all medicines including heart, hypertension, over-the-counter, herbal products, vitamins etc.)

1.	4.
2.	5.
3.	6.

Continued on the back

ALLERGIES: (list drug/food/latex, etc) _____

MEDICAL HISTORY (do you now or have you had in the past; please answer all questions)

<input type="checkbox"/> Yes	<input type="checkbox"/> No	Heart problems: heart attack (MI), bypass, angioplasty, stent, angina
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Heart failure
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Stroke or TIA
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Blockage in artery to: legs, neck or kidney
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Thyroid problems
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Breathing or lung problems
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Muscle, joint or back problems
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Seizure disorder
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Mental/nervous disorder
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Pregnancy (now or within the last 3 months)
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Recent surgery or any other condition that might hinder you from exercise
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Current cigarette smoker or quit within the last 6 months
<input type="checkbox"/> Yes	<input type="checkbox"/> No	High blood pressure (140/90 or higher) or taking medicine to lower blood pressure
<input type="checkbox"/> Yes	<input type="checkbox"/> No	High blood cholesterol (200 or higher) or taking medicine to lower cholesterol level
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Family history of early heart disease (MI) or sudden death (father/brother before the age 55 or mother/sister before age 65)
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Diabetes (how old were you when diabetes began? _____)
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Excess Weight ("20 extra pounds" especially around the waist)

Current Symptoms (please answer all questions)

<input type="checkbox"/> Yes	<input type="checkbox"/> No	Pain, discomfort in the chest, neck, jaw, or arms
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Shortness of breath at rest or with mild exertion
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Fatigue or unusual tiredness with usual activities
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Dizziness or syncope (loss of consciousness)
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Pain or tightness in hips or calves with walking (claudicating)
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Other symptoms: _____

Summary explanation of above (if needed) _____

Your signature authorizes an ASI staff member to obtain a medical clearance from your physician if you are pregnant, have diagnosed heart problems, diabetes, metabolic disorders, respiratory problems or any other risk factors considered necessary. **It is the responsibility of the participant to update this form on a yearly basis and to notify ASI staff of any changes.**

Signature _____ Date _____

ASI Staff Use Only	
Cleared for Exercise Participation: Yes _____ No _____	Staff Initial _____ Date _____
Physician Letter/Form: Date Sent: _____	Date Received: _____ Reviewed Staff: _____
Risk Stratification: Level - <input type="checkbox"/> One <input type="checkbox"/> Two <input type="checkbox"/> Three <input type="checkbox"/> Four	