



149 Raymond Hirsch Pkwy • Suite 1 • PO Box 9 • White House, TN 37188

Phone: (615) 672-2977 • Fax: (615) 672-2979

P.I.M. Medical Fitness Intake Form

Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____

Zip code: _____ E-mail address: _____

Phone: (H): _____ (W): _____ cell: _____

Sex:(please circle one) male / female SS#: _____

Emergency Contact: name _____ phone # _____

For a complete and thorough assessment please answer the following questions

1. Are you currently being treated by any of the following?

Medical doctor	yes	no
Osteopath	yes	no
Dentist	yes	no
Psychiatrist/ Psychologist	yes	no
Chiropractor	yes	no

2. List any surgeries or other conditions for which you were hospitalized.

Date	Surgery/ Hospitalization/ Reason
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

3. List any injuries for which you were treated (include fractures, dislocations, sprains)

Date	Surgery/ Hospitalization/ Reason
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____



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MODIFIED PHYSICAL ACTIVITY READINESS QUESTIONNAIRE (PAR-Q)

Name: _____ Date: _____ Birth Date: _____ Age: _____
Home Phone #: _____ Work Phone #: _____
Primary Physician: _____ Primary Physician's Phone #: _____

Regular exercise is associated with many health benefits, yet any change of activity may increase the risk of injury. Completion of this questionnaire is a first step when planning to increase the amount of physical activity in your life. Please read each question carefully and answer every answer question honestly.

- Yes No 1) Has a doctor ever said that you have a heart condition and recommended only medically supervised activity?
- Yes No 2) When you do physical activity, do you feel pain in your chest?
- Yes No 3) Have you developed chest pain in the past month?
- Yes No 4) Do you ever lose consciousness or do you lose your balance because of dizziness?
- Yes No 5) Do you have a bone or joint problem that may be made worse by a change in your physical activity?
- Yes No 6) Has a doctor ever recommended medication for your blood pressure or a heart condition?
- Yes No 7) Are you pregnant?
- Yes No 8) Do you have insulin dependent diabetes?
- Yes No 9) **Male:** are you 45 years or older?/ **Female:** are you 55 years or older?
- Yes No 10) Do you know of any other reason you should not exercise or increase your physical activity?

If you answered "Yes" to **any** of the above questions, we require you to talk with your doctor BEFORE you become more physically active. We will fax a note to tell your doctor your intent to exercise and to which questions you answered, "Yes" to. If you honestly answered "No" to all questions you can be reasonably positive that you can safely increase your level of physical activity GRADUALLY. If your health changes so you then answer, "Yes" to any of the above questions please tell your physician and your fitness instructor.

Participant's Signature: _____ Date: _____



INFORMED CONSENT FOR AN EXERCISE TEST

1) Responsibilities of the Participant:

Information you possess about your health status or previous experiences of overall health, diseases or heart related symptoms might affect the safety of your exercise test and therefore fitness prescription. Your prompt reporting of these and any other unusual feelings with effort during the exercise test is of great importance. You are responsible for fully disclosing your medical history as well as symptoms that may occur during the tests. You are also expected to report all medications and in particular, those taken today prior to your test.

2) Benefits to be Expected:

The results of the exercise test may assist in the type of physical activities you might do with low risk.

3) Inquiries:

Any questions about the procedures used in the exercise test or the results of your test are encouraged. If you have any concerns or questions, please ask us for further explanation.

4) Use of Medical Records:

The information that is obtained during exercise testing will be treated as privileged and confidential.. It is not to be released or revealed to any person without your written consent. The information obtained, however, may be used for statistical analysis or scientific purposes with your right to privacy retained.

5) Freedom of Consent:

I hereby consent to voluntarily engage in an exercise test to determine my exercise capacity and state of cardiovascular health. My permission to perform this exercise test is given voluntarily. I understand that I am free to stop the test at any point, if I so desire.

I have read this form, and I understand the test procedures that I will perform and the potential 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 the test.

(Signature)

(Date)

(Signature of witness)

(Date)

4. Have you EVER been diagnosed with any of the following?

Cancer	yes	no
If yes, what kind _____		
Heart problems	yes	no
High blood pressure	yes	no
Asthma	yes	no
Emphysema	yes	no
Chemical dependency (alcoholism)	yes	no
Thyroid problems	yes	no
Diabetes	yes	no
Multiple sclerosis	yes	no
Rheumatoid arthritis	yes	no
Other arthritic conditions	yes	no
Depression	yes	no
Hepatitis	yes	no
HIV/ AIDS	yes	no
Tuberculosis	yes	no
Stroke	yes	no
Kidney disease	yes	no
Anemia	yes	no
Epilepsy	yes	no
Other _____		

5. Has anyone in your immediate family (parents, brothers, sisters) ever been treated for any of the following?

Diabetes	yes	no
Tuberculosis	yes	no
Heart disease	yes	no
High blood pressure	yes	no
Stroke	yes	no
Kidney disease	yes	no
Cancer	yes	no
Arthritis	yes	no
Anemia	yes	no
Headaches	yes	no
Epilepsy	yes	no
Mental illness	yes	no
Alcoholism (chemical dependency)	yes	no

6. List any PRESCRIPTION medication you are currently taking (include pills, injections, and/ or skin patches) and why you are taking it (blood pressure, cholesterol...).

7. Which of the following OVER THE COUNTER medications have you taken in the past week?

Aspirin	yes	no
Tylenol	yes	no
Advil/ Motrin/ Ibuprofen	yes	no
Laxatives	yes	no
Decongestants	yes	no
Antihistamines	yes	no
Antacids	yes	no
Vitamins/ mineral supplements	yes	no
Other _____		

8. How much coffee or caffeine containing beverages do you drink each day?

9. How many packs of cigarettes do you smoke each day?

10. How many days per week do you drink alcohol?

11. If one drink equals one beer or glass of wine, how much do you drink at a time?
