Healthy Ways Intake Form and Health Screening Questionnaire

Name_____ Today's date (MM/DD/YYYY): _____

Date of Birth (MM/DD/YYYY): _____ Age: _____

Preferred phone: _____(home/cell) Alternate phone: _____(home/cell)

Email: _____

Emergency Contact

Name: _____ Relationship: _____

Preferred phone: _____(home/cell) Alternate phone: _____(home/cell)

Physician Info

Primary physician: _____ (_____) _____

Other physicians involved in your treatment/care: (use reverse side if necessary)

Name	Specialty	Phone number
_____	_____	(_____) _____
_____	_____	(_____) _____
_____	_____	(_____) _____

How did you learn about the Healthy Ways program? _____

Medical History – General

Have you ever had any of these health problems?

Pulmonary (lung) problems	☐ Yes	☐ No
Heart problems or surgery	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Altered heart rate	☐ Yes	☐ No
Dizziness or fainting (unrelated to cancer treatment)	☐ Yes	☐ No
Chest, neck or arm pain	☐ Yes	☐ No
Pain or cramping in legs while walking	☐ Yes	☐ No
Short-term weakness on one side of the body	☐ Yes	☐ No
Elevated blood pressure	☐ Yes	☐ No
Low blood pressure	☐ Yes	☐ No
High cholesterol	☐ Yes	☐ No
Smoker or previous smoker	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No

If the answer is yes to any of the above, please describe briefly:

_____

_____

Other major illnesses (include surgeries/accidents/chronic pain)

_____

_____

_____

Medications/Lifestyle/Other:

List current medications (including vitamins and over-the-counter)

_____
_____
_____

Describe your health at the present time: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

List types of exercise you participate in regularly and describe the frequency of your practice

_____
_____
_____

Do you have any physical limitations that restrict your daily living activities or ability to exercise?

☐ No ☐ Yes If yes, please explain:

_____
_____

Are you currently working? ☐ Yes ☐ No

What is your level of activity at work? ☐ Completely sedentary ☐ Moderately active ☐ Very active

Describe your past experience with resistance training and aerobic training:

_____
_____
_____

Do you have any concerns about starting this exercise program?

_____
_____
_____

Are you currently following any specific diet plan or weight loss program? If so, please list all that apply.

_____
_____
_____

What, if any, weight management or weight loss program/s have you tried in the past?

_____
_____
_____

Who in your household is responsible for food shopping and food preparation?

_____
_____
_____

How many meals/snacks per week are eaten outside the home?

_____
_____
_____

Do you have any concerns about changing your food choices and eating behaviors?

_____
_____
_____

Are you willing to commit to precisely tracking your exercise and food intake through the use of a journal or log for the duration of the program?

_____
_____
_____

How will you determine your personal success/satisfaction with this program?

_____
_____
_____

What expectations do you have from this program?

_____
_____
_____

How will you determine personal success/satisfaction with this program?

_____
_____
_____

What is your preferred class time? Please number them from 1 to 2 with 1 being your first choice. If a class time is impossible for you to make, please leave it blank.

____ Tuesday AND Thursday 9:00 – 10:00 a.m.
____ Tuesday AND Thursday 6:00 – 7:00 p.m.