

Participant Information Sheet

Please complete sections 1-6 on the following information sheets.

1

Name: _____ Age: _____ Sex: _____ Date: _____

Address: _____ Zip: _____

Phone: _____ (Hm) _____ (wk)

Fax: _____ e-mail: _____

Employer: _____ Occupation/Title _____

Physicians Name: _____ Phone: _____

2

3

Briefly describe a typical week of exercise training in terms of workout type, duration (minutes) and intensity (hard/mod./easy). Include x-training workouts such as weight training.	Please rate your top 3 goals related to your exercise program from the list below. Put a number 1 next to the most important goal and then a 2 and 3 for the next two goals in order of priority.
Monday	Weight management (health):
Tues.	Weight management (other):
Wed.	Lower disease risk:
Thurs.	Improve performance (endurance):
Friday	Improve performance (strength):
Sat.	Lower injury risk
Sun.	Improve emotional wellbeing:

4 Measure your resting heart rate (RHR)

<p>You should take your heart rate first thing in the morning prior to any activity. Record your RHR in the box to the right prior to participating in your Cardio-Metabolic Exercise Test.</p> <p>The most common sites to take your pulse are the carotid artery or the radial artery. The carotid artery is found by locating the groove in the neck adjacent to the voice box. Take your pulse on one side only and lightly palpate. The radial artery is found by placing your index fingers on the palm side of your opposite wrist just below your hand. A slight flexion bend at the wrist make it easier to find the pulse. Heart rate is taken by counting pulse intervals. Usually, a resting heart rate is measured by counting the number of beats for 15 seconds, then multiplying that number by four. Your first pulse is "zero" as you begin the 15-second count. A normal resting heart rate will usually run between 50-85 beats per minute (bpm)</p>	<p style="font-size: 1.2em;">My Resting Heart Rate is:</p> <div style="border: 1px solid black; width: 80px; height: 60px; margin: 0 auto;"></div> <p style="font-size: 1.2em;">bpm</p>
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Medical/Health History Form

CARDIAC:

Have you ever had heart related problems such as:

Heart Disease Yes / No _____
 Heart Murmur Yes / No _____
 Abnormal EKG Yes / No _____

Have you ever experienced the following:

Skip heart beats Yes / No _____
 Sudden fast heart rate Yes / No _____
 Chest discomfort Yes / No If yes then:
 Where _____
 When _____
 Associations _____
 Relieved by (symptoms-sweaty, dizzy, etc.) _____

Do you have high blood pressure or are taking blood pressure medication? Yes / No _____

Do you have low blood pressure? Yes / No _____

Do you have respiratory difficulty? Yes / No _____

Any unusual pain or swelling in you legs or arm. Yes / No _____

Are you presently taking medications Yes / No _____
 please list:
 1. _____
 2. _____

Are you diabetic? Yes / No _____

Signature: _____ **Date:** _____

FAMILY HISTORY:

Do you have a family history for:

Heart Disease Yes/No If yes then list who and approximate age at onset _____

Hypertension Yes/No Who: _____

Diabetes Yes/No Who: _____

MUSCULOSKELETAL INJURIES:

Have you had any muscular/bone/joint pain or discomfort during the past year? Yes/No If yes, describe: _____

Have you had this problem in the past 7 days? Yes/ No _____

PAST HISTORY:

Have you had any operations or major illness? Yes / No _____

LIFESTYLE HISTORY:

Are you currently on an exercise program? Yes / No
 If yes, what type of exercise: _____

Days per week you exercise....(1-2) (3-4) (5+)
 Minutes of exercise per session.. (<30) (30-60) (60+)

Do You Smoke? Yes / No

If yes, how many ____/day

Are you on any special diet? Yes / No

Do you drink Alcohol?

Yes/No drinks per week _____

Do you consume caffeine? Yes/No

cups per day _____

Do you have any limitations or concerns that may affect your participation in an exercise and diet program? Y/N _____

⑥ INFORMED CONSENT FORM

I hereby consent to voluntarily engage in an exercise test to determine my cardio-metabolic fitness. I also consent to a body composition test (skin folds &/or circumferences) and the taking of samples of my exhaled air during exercise to properly measure my oxygen consumption. It is my understanding that the information obtained will help me and the program staff to evaluate my exercise and future activities.

An Exercise Physiologist will conduct the above evaluations - all evaluations are personal and confidential. Please note, the EKG monitored exercise treadmill test and the blood profile are NOT diagnostic tests. The EKG is used to accurately determine your heart rate at specific work loads for the purpose of assessing functional capacity. Only a physician can determine the diagnostic value of these tests. A physician referral will be made if EKG abnormalities are observed during the treadmill exercise test, if blood pressure measurements are above 140/90 and if blood parameters are classified as high risk. If you wish to stop at any time during these tests, or feel that a test may be detrimental to your health, you are free to do so.

All testing including the blood profile and treadmill tests are to be used for baseline comparisons and as a tool to select training protocols. These tests do not take the place of a physical exam by a licensed physician or can they be used to suggest that you are safe to exercise.

Before I undergo the test, I certify to the program that I am in good health and have had a physical examination conducted by a licensed medical physician within the last _____ months. Further, I hereby represent and inform the program that I have completed the pretest history interview presented to me by the program staff and have provided correct responses to the questions as indicated on the readiness questionnaire or as supplied by the interviewer. Consequently, I understand that it is important that I provide complete and accurate responses to the interviewer and recognize that my failure to do so could lead to possible unnecessary injury to myself during the test.

I have read this form and understand the risk and I realize that there are remote possibilities of injury or other complications, such as a heart attack, which may occur during such a test or in the course of completing an assigned exercise program subsequent to such testing procedures.

I have been informed of the need for a physician's approval (and a medical exam) before participation in a program of progressive activity and/or nutrition modifications if I have a medical condition and/or taking medications, or have concerns regarding my health that may prove harmful for me if I participate.

I understand the testing procedures that I will perform and I consent to participate in these tests.

Signature

Print Your Name

Date

Witness

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