



www.novamedspa.com

21785 Filigree Court, Suite 100 Ashburn, Virginia 20147 703.554.1130 fax: 703.554.1133

## Client Profile Physical Activity Readiness Questionnaire

Please Print

Date: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Contact Number:

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_  Female  Male

1. Are you currently involved in any exercise program?  Yes  No

If yes, please list how long and what type of exercises.

\_\_\_\_\_  
\_\_\_\_\_

2. **Occupation:** Please explain your position along with the physical activity and mental responsibilities involved.

\_\_\_\_\_  
\_\_\_\_\_

3. What kind of sports do you enjoy most? Please list.

\_\_\_\_\_  
\_\_\_\_\_

4. What sports did you enjoy as a child?

\_\_\_\_\_  
\_\_\_\_\_

**Medical Information:**

1. Do you suffer from back pain?  Yes \_\_\_\_\_  No
2. Are you sensitive to touch/pressure in any area?  Yes \_\_\_\_\_  No
3. Do you have tension or soreness in any specific area?  Yes \_\_\_\_\_  No
4. Do you experience frequent headaches?  Yes  No
5. Are you pregnant?  Yes  No
6. Do you have high blood pressure?  Yes  No
7. Do you have high cholesterol?  Yes  No
8. Are you epileptic?  Yes  No
9. Have you ever had surgery?  Yes  No

If yes, what type and when? \_\_\_\_\_

10. Have you ever broken any bones?  Yes \_\_\_\_\_  No
11. Do you have difficulty sleeping?  Yes  No
12. Do you have experience fatigue or lack of energy?  Yes  No
13. Do you experience cold hands or feet?  Yes  No
14. Have you been advised by a physician to avoid any type of exercise?  Yes  No

If yes, what type: \_\_\_\_\_

15. Have you ever been knocked unconscious or suffered a concussion?  Yes  No

If yes, please state how many times and the dates. \_\_\_\_\_

16. Do you have a cardiac condition?  Yes  No
17. Do you have allergies?  Yes  No
18. Have you ever seen a Nutritionist/Registered Dietician?  Yes  No
19. Do you smoke or have you smoked in the past?  Yes  No

20. What is the heaviest you have ever weighed? \_\_\_\_\_  
How old were you at the time? \_\_\_\_\_

21. Please list any medications you are currently taking?

---

22. Have you ever had any of the following; physical therapy, chiropractic, massage, or acupuncture?  Yes  No

23. How much time do you spend in a seated position? \_\_\_\_\_

24. How many hours of sleep do you get at night? \_\_\_\_\_

25. Do you drink coffee?  Yes  No If so, how much? \_\_\_\_\_

26. How many meals do you eat each day? *(List the number and time of day you usually eat these meals.)*

I, the undersigned, have read, understood, and have answered the above questions fully and truthfully. I am aware of my responsibilities to consult with my personal physician regarding my medical fitness to engage in exercise. I do hereby intend to be legally bound for myself and waive release of any and all rights and claims for damages I may have against *The Medical Spa at Nova* and the exercise professional administering the exercise program provided to me.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Print Name: \_\_\_\_\_