MORRIS
Cardiovascular and Risk Reduction Center

# PRE-SCREENING QUESTIONNAIRE

## PERSONAL INFORMATION

**Name:** _____ **Date:** _____
**Phone:** _____H/W/C *(primary)*
_____H/W/C *(secondary)*
**Text okay? YES NO**

**Email:** _____
**Address:** _____

**Is our location convenient for you?** _____

**Height:** _____ **Weight:** _____ **DOB:** _____ **Age:** _____ **Sex:** _____

**Emergency Contact:** _____ **Relationship:** _____
**Phone:** _____ H/W/C
_____ H/W/C

**Are you currently a patient of Dr. Morris?** _____

**How did you hear about us?** _____

## PERSONAL PROFILE

**Primary health goal:**

_____
_____

**Obstacles:**

_____
_____

**Current/previous** *(circle one)* **physical activity routine:**

_____
_____
_____

**If not currently physically active, how long ago were you active?**

_____

**How long have you been thinking about joining a fitness/health program?**

_____

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**Do those in your household share similar health goals?**

_____

_____

**Do you feel supported by your health goals within your home?**

_____

_____

## NUTRITION PROFILE

**How would you rate your nutritional intake/eating habits?**

| 0 | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|
| *Poor* | | | | | *Excellent* |

**How many meals do you eat daily?** _____

**How many glasses of water do you drink daily?** _____

**Specific nutrition goals:**

_____

_____

**Injuries/Surgeries/Procedures:** **DATE**

_____

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| | | |
|---|---|---|
| Has there been any significant change to your health/weight in the past 6 months? | Y/N | Comments: |
| Has a Doctor ever indicated that you have heart disease or heart trouble? | Y/N | Are you cleared for physical activity? |
| In the past month, have you had chest pain when you were not performing any physical activity? | Y/N | Comments: |
| Do you have pain in your chest with physical activity? | Y/N | Comments: |
| Do you lose your balance because of dizziness while at rest or while performing physical activity? | Y/N | Comments: |
| Do you ever lose consciousness while at rest or while performing physical activity? | Y/N | Comments: |
| Do you have any bone or joint problems that could be made worse by a change in your physical activity? | Y/N | Comments: |
| Do you have any past surgeries we should be aware of? | Y/N | Please List: |
| Do you have Asthma? | Y/N | Treatment needed in the case of emergency: |
| Do you have Diabetes? | Y/N | Controlling your diabetes with medication? |
| Is your doctor currently prescribing any medication for your blood pressure or for a heart condition? | Y/N | Please list: |
| Are you currently on a medical profile exempting you from physical activity? | Y/N | Comments: |
| Are you currently under the instructions or care of a Health Professional? | Y/N | Provider Name:<br>Phone #:<br>Comments: |
| Do you know of ANY other reason why you should not engage in physical activity? | Y/N | Comments: |

**The above information I have provided is true and correct and I will notify appropriate staff members of Morris Cardiovascular of any changes to my health, which may affect my physical performance and safety while at the Morris Cardiovascular and Risk Reduction Center.**

Printed Name: _____ Date: _____

Signature: _____ Witness: _____