Corona Temecula Orthopaedic Associates
MEDICAL GROUP INC.

PERSONAL TRAINING HEALTH HISTORY QUESTIONNAIRE

Answer each question by printing the necessary information. Your answers are confidential.

NAME	DATE OF BIRTH: / /	GENDER ( ) M ( ) F	AGE
ADDRESS			
CITY	STATE	ZIP	
HOME PHONE	WORK/CELL PHONE		
EMPLOYER	OCCUPATION		
HOW DID YOU HEAR ABOUT US?			

EMERGENCY CONTACT INFORMATION

NAME	DATE OF BIRTH: / /	GENDER ( ) M ( ) F	AGE
ADDRESS			
CITY	STATE	ZIP	
HOME PHONE	WORK/CELL PHONE		

MEDICAL INFORMATION

PHYSICIAN:	PHONE

ARE YOU UNDER THE CARE OF A PHYSICIAN OR OTHER HEALTHCARE PROFESSIONAL FOR ANY REASON?

ARE YOU TAKING ANY MEDICATIONS?

NAME	DOSAGE/FREQUENCY	REASON FOR TAKING

PLEASE LIST ANY ALLERGIES:

341 Magnolia Avenue, Suite 103 • Corona, California 92879 • Telephone: (951) 284-2827 • Fax: (951) 284-1666

Emile Yacoub, D.P.T., O.C.S., C.S.C.S.
Director of Physical Therapy and Wellness Center

Coleen Liagas, M.S.P.T., O.C.S.
Physical Therapist

Claire Payken, D.P.T.
Physical Therapist

Neilvon Langas. P.T.A.
Physical Therapist Assistant

Mellissa Rouhe, R.N., M.P.H., C.H.E.S.
Health Education Coordinator

Patty Bernabe, C.P.T.
Personal Trainer

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MEDICAL INFORMATION CONTINUED

		EXPLANATION
Do you have high blood pressure, heart problems, or wear a pacemaker	❑ Yes ❑ No	
Do you have angina or chest pain?	❑ Yes ❑ No	
If so does it occur with coughing or breathing?	❑ Yes ❑ No	
Is it related to food or alcohol consumption?	❑ Yes ❑ No	
Is it relieved in a comfortable position?	❑ Yes ❑ No	
Do you have osteoporosis, osteoarthritis, or rheumatoid arthritis?	❑ Yes ❑ No	
Do you have diabetes or are you hypoglycemic?	❑ Yes ❑ No	
Are you anemic?	❑ Yes ❑ No	
Do you have a history of high cholesterol?	❑ Yes ❑ No	
Do You have a history of seizures, strokes or circulatory problems?	❑ Yes ❑ No	
Are you currently pregnant?	❑ Yes ❑ No	
Do you have a history of asthma, kidney disease, or thyroid disorder?	❑ Yes ❑ No	
Is there any reason you should not participate in a regular exercise program?	❑ Yes ❑ No	
Do you smoke or use any form of tobacco?	❑ Yes ❑ No	
If so, how many per day and for how many years?	# Daily	For # Years

Please list any other medical conditions:

LIFESTYLE AND EXERCISE HABITS

Are you unaccustomed to vigorous exercise?

Is your occupational stress level: ❑ Low ❑ Medium ❑ High

Is your energy level: ❑ Low ❑ Medium ❑ High

How much of the following do you intake daily/weekly?

Caffeine: Butter:

Alcohol: Cream:

How many colds do you have per year?

Are you on any specific food or diet plan? If so, please describe.

Do you take any dietary supplements?

Have you experienced any recent weight fluctuations (Weight gain or weight loss)?

How would you describe your current nutritional habits?

Please describe your current musculoskeletal conditions you have incurred such as a muscle pull, sprains, fractures, surgeries or general discomfort.

Head/Neck:

Upper Back:

Shoulder/Clavicle:

Arm/Elbow:

Wrist/Hand:

Lower Back:

Hip/Pelvis:

Knee:

Ankle/Foot:

What are your short term goals (2-4 weeks)?

What are your long term goals (6 plus months)?

PRINT NAME

SIGNATURE

DATE

Personal Training Policies

In order to ensure a safe and positive experience during you personal training, we ask that you please abide by a few guidelines.

- As a safety precaution, children or guests are ***not*** allowed in the gym during your visit. They will be asked to wait in the waiting room.
- Shoes must be worn at all times. ***No sandals or open toe style shoes.***
- No outside food or beverages are allowed in the gym area, unless approved by your personal trainer.
- We do not allow cell phone use in the gym.
- Payments are due at the time of service.
- Notification for Cancellations must given 24 hrs prior to your scheduled appointment or you will forfeit that visit.

The staff of Corona-Temecula Orthopaedic Physical Therapy and Wellness Center are dedicated to providing you with the best quality care. To achieve this we ask for your assistance. It is your responsibility to follow the recommendations of your Personal Trainer. It is important that you be consistent with your exercise program and attend all of your scheduled appointments within a reasonable timeframe in order to achieve your goals.

Signature: ____ Date: ______________________________

By signing, I declare that I have read and understand the above outlined policy.

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Physical Therapy & Wellness Center Liability Waiver

Please fill out all information requested below

I, (print name)_____________________________, give my consent to participate in the physical fitness evaluation program conducted by Corona-Temecula Orthopaedic Associates Physical Therapy and Wellness Center.

BENEFITS:

Participation in a regular program of physical activity has been shown to produce positive changes in a number of organ systems. These changes include increase work capacity, improved cardiovascular efficiency, and increased muscular strength, flexibility, power, and endurance.

RISKS:

I recognize that exercise carries some risk to the musculoskeletal system (sprains, strains etc.) and the cardiorespiratory system (dizziness, discomfort in breathing, heart attack, etc.). I hereby certify that I know of no medical problems (except those noted below) that would increase my risks of illness and/or injury as a result of my participation in a regular exercise program.

TESTING AND EVALUATION RESULTS:

I understand that I will undergo initial testing to determine my current physical fitness status. The testing will consist of completing this health inventory, taking a step test or a bicycle ergometer test for cardiovascular fitness, and being tested for muscular fitness and body composition.

I further understand that such screening is intended to provide Corona-Temecula Orthopaedic Associates Physical Therapy and Wellness Center with essential information used in the development of an individual fitness program. I understand that my individual results will be made available only to me. I also understand that the testing is not intended to replace any other medical test or the services of my physician. I will be provided a copy of all test results upon my request. I may share the results with whomever I please, including my personal physician. By, signing this consent form I understand that I am personally responsible for my actions during my tenure at Corona-Temecula Orthopaedic Associates Physical Therapy and Wellness Center, and I waive the responsibility of this center if I should incur any injury as a result of my negligence.

NAME: ___________________________________ Date: __________________________________

SIGNATURE:_____________________________ Witness: ______________________________

Signature of Parent
Or Guardian (for minor participants):____

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