

Fitness Assessment: General Information

Date: _____ How did you hear of us? _____

Name: Last: _____ First: _____ M.I.: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: Home: _____ Work: _____

Other: _____ E-Mail: _____ @ _____

Age: ____ Gender: ____ Marital Status: ____ Occupation: _____

Date of Birth: ____/____/____

Race or Ethnic Origin (please circle one): African American American Indian or Alaskan Native

Asian Hispanic or Latino Pacific Islander or Native Hawaiian Caucasian Unspecified

Phone: Home: _____ Work: _____

Other: _____ E-Mail: _____ @ _____

Emergency Contact Name: _____ Phone: _____

Physician Name: _____

Address: _____

Phone: _____

The care you need to get better, stronger, faster.

Full Disclosure/Client Rights

Dear BDI Client:

Body Dynamics, Inc. is dedicated to providing you with the highest quality clinical care for neuromusculoskeletal rehabilitation, health promotion, fitness and wellness. Our goal is to help you achieve and maintain your maximum potential for a vibrant, productive, and healthy lifestyle. To that end, BDI integrates the expertise of a variety of health care professionals, including physical therapists, massage therapists, acupuncturists, personal trainers, athletic trainers, pilates and other fitness instructors, and registered dieticians.

Our Associates have chosen to work together to create a center for excellence for rehabilitation, health promotion, fitness, and wellness. We hold ourselves to the highest standards within our given areas of expertise. BDI supports and creates many in-house opportunities for continued competencies, integration of best practices and latest evidence, and collaboration among staff members. When clients participate in multiple services, we emphasize coordination of care and communication among service providers.

During the course of your care, additional services may be recommended to you. These recommendations will be based on objective findings and/or the clinical expertise of the associate you are seeing. Upon receiving such recommendations, please be advised that you reserve the right to:

1. Decline the recommendations;
2. Accept the recommendations, and request collaboration with your own providers;
3. Accept the recommendations, and request collaboration with BDI's providers.

If at anytime during the course of your care at BDI, you are not achieving your goals – we will immediately re-assess your case, revise your plan of care as necessary, or refer you to another provider outside of Body Dynamics.

We believe that integrated care that is immediately responsive to clients' needs is a vital part of the future of healthcare. We also recognize that you retain the right to choose what services you will receive, where you will receive them, and from whom.

When entering into a service at Body Dynamics, we recognize the inherent trust that you place in us to make appropriate recommendations based on the best available evidence. We pledge to hold that trust inviolate.

If you have any questions, do not hesitate to contact me directly.

Sincerely,

Jennifer M. Gamboa, DPT, OCS, MTC
President/Director of Clinical Services

Client Signature: _____ Date: _____

Description of FitTEST Solutions™ and Release of De-identified Fitness Data

FitTEST Solutions™ is a physical therapist-based fitness assessment program designed to establish baseline and follow-up measures of individual health risk factors, biomechanical factors, posture, relative strength, flexibility, physical functional capacity, and aerobic capacity.

The tests and measures contained in FitTEST Solutions™ are appropriate for adults, ages 18 to 80 with no known cardiopulmonary or degenerative neurological disorder.

You will be provided with a “Summary of Findings” that will summarize the data collected during the assessment. This is not a diagnostic report to identify any underlying medical conditions. If you or your tester suspects any underlying medical conditions that would preclude you from safely participating in this fitness assessment, you should consult your physician immediately.

Upon completion of this test, you will also receive some general recommendations for follow-up as well as specific recommendations for aerobic training and basic home exercise that target your particular strength, flexibility, and endurance challenges. Your tester may also make additional recommendations to ensure that you meet your specific fitness goals.

FitTEST Solutions™ stores your data in a secure, password protected database, compliant with HIPPA (The Health Insurance Portability and Accountability Act of 1996) standards.

Periodically, the developers of FitTEST Solutions™ will request de-identified data from licensed FitTEST Solutions™ Providers to update the data used within the program to calculate fitness categories in relationship to age/gender norms. Under no circumstances will this data be linked back to your name.

Informed Consent

I, the undersigned, understand the intent and purpose of the FitTEST Solutions™ physical therapist-based fitness assessment program.

I agree that I will fully disclose any underlying medical conditions that may preclude me from safely participating in the fitness assessment.

I understand that de-identified data collected during my fitness assessment may be used in pooled analysis to update the normative data used to benchmark fitness categories.

Signature:

Date:

Registration

Name:		Birthdate:					
Street:		City:		State:		Zip:	
Phone Number:		email:					

Pre-participation Health Screening |

Name: _____

Date: _____

Instructions: After carefully reading each statement below, please mark No or Yes.

Have you had or been diagnosed with...

No

Yes

	No	Yes
1. A heart attack?		
2. Heart surgery?		
3. Cardiac catheterization procedure?		
4. Angioplasty (PTCA)?		
5. Pacemaker/implantable cardiac defibrillator?		
6. Cardiac rhythm disturbance?		
7. Heart valve disease?		
8. Heart failure?		
9. Heart transplantation?		
10. Congenital heart disease?		

Have you experienced...

No

Yes

	No	Yes
1. Chest discomfort with exertion?		
2. Unreasonable breathlessness?		
3. Dizziness, fainting, or blackouts		
4. Do you take heart medications		

Do you have other health issues, such and ...

No

Yes

	No	Yes
5. Diabetes?		
6. Asthma or lung disease?		
7. Burning or cramping sensation in your lower legs when walking short distances?		
8. Musculoskeletal problems that limit your physical activity?		
9. Concerns about the safety of exercise?		
10. Take prescription medication(s)?		
11. Currently pregnant?		
12. Musculoskeletal problems that limit your physical activity?		

If you marked any of the above statements as "yes", you should consult your physician or other appropriate health care provider before engaging in exercise. You may need to use a facility with medically qualified staff.

Cardiovascular risk factors

No

Yes

	No	Yes
1. Are you a man older than 45 years?		
2. Are you a woman older than 55 years, have had a hysterectomy, or are post-menopausal?		
3. Do you smoke, or have you quit smoking within the previous 6 months?		
4. Is your systolic blood pressure \geq 140 mmHg or diastolic \geq 90mmHG?		

Cardiovascular risk factors (continued)	No	Yes
5. Is your blood pressure unknown to you?		
6. Do you take blood pressure medication?		
7. Is your blood cholesterol level > 200 mg/dl?		
8. Is your cholesterol level unknown to you?		
9. So you have a close blood relative who had a heart attack or heart surgery before the age of 55 (father or brother) or age 65 (mother or sister)?		
10. Are you physically inactive (i.e., you get <30 minutes of physical activity 3 or fewer days per week)		
11. Are you > 20 lbs overweight?		

If you marked 2 or more of the above statements in this section as “yes”, you should consult your physician or other appropriate health care provider before engaging in exercise. You may need to use a facility with medically qualified staff to guide your exercise program.

If you marked “no” for the above statements in both sections, should be able to exercise safely without consulting your physician or other appropriate health care provider in a self guided program or almost any facility that meets your exercise program needs.

For Internal Office Use Only	No	Yes
1. Client consulted?		
2. Physician consulted?		
3. No additional clearance necessary?		

Sources: American College of Sports Medicine and American Heart Association, 1998.

Medical History |

Name: _____

Date: _____

Instructions: After carefully reading each statement below, please mark the most appropriate box.

	Excellent	Good	Fair	Poor
General Health				

Past or present medical conditions

	No	Yes		No	Yes
Anemia			Heart Attack		
Angina/Chest Discomfort			Heart Disease		
Arthritis			Hepatitis		
Asthma			Hernia		
Bowel Dysfunction			High Blood Pressure		
Cancer			Kidney Disease		
Changes in Urination			Metal/other implant		
Chemical Dependency			Nausea/vomiting		
Circulatory Disease			Neurological Disorder		
Current Pregnancy			Night pain		
Depression			Numbness and Tingling		
Diabetes			Osteoporosis		
Dizziness			Sexual Dysfunction		
Eating Disorder			Shortness of Breath		
Emphysema			Stroke		
Epilepsy			Thyroid Problems		
Fainting			Tuberculosis		
Fatigue			Unexplained weight change		
Fever/chills/sweats			Weakness		
Headaches					

Additional Explanations ((including other conditions not previously mentioned, and any relevant Family History of above conditions):

	No	Yes
Major Medical Problems/Hospitalizations in the past year (check one)?		

If yes, please explain.

	No	Yes
Surgical History (check one)?		

If yes, please record name and date of procedure.

	No	Yes
Past/present musculoskeletal injuries (check one)?		

If yes, please record following information.

<u>Injury</u>	<u>Date</u>	<u>Treatment</u>	<u>Recovered?</u>

List Prescription Medications:

List Over-the-counter Medications:

	No	Yes
Currently use tobacco? [If yes, please specify packs per day: _____, # yrs using tobacco _____]		
Previously used tobacco? [If yes, please specify ppd: _____, # yrs _____, quit date _____]		
Alcohol? [If yes, please specify # of drinks per day: _____, per week _____, OR per month _____]		
Caffeine? [If yes, please specify # of drinks per day: _____]		
During the past month have you felt down, depressed, or hopeless?		
During the past month, have you lost interest or pleasure in doing things?		
Is this something for which you would like immediate help?		
Is this something you would like to address in the near future?		

Current Recreational/Fitness Activities (type, intensity, duration, and frequency):

Goals for Fitness:

1. _____ 2. _____ 3. _____

Physical Activity | Readiness to Change Score

Name: _____

Date: _____

Instructions: After carefully reading each statement below, please check the column that corresponds to your answer.

Definitions:

Physical activity or exercise: includes such activities as walking briskly, jogging, bicycling, swimming, or any other activity in which the exertion is at least as intense as these activities.

Regular physical activity: must add up to a total of 30 minutes or more per day and be done at least 5 days per week. For example, you could take one 30-minute walk, or take three 10-minute walks for a daily total of 30 minutes

	No	Yes
1. I am currently physically active [if yes, skip to question 3].		
2. I intend to become more physically active in the next 6 months.		
3. I currently engage in <i>regular</i> physical activity.		
4. I have been <i>regularly</i> physically active for the past 6 months.		

Sources: Marcus BH, 1992; Marcus and Forsyth, 1992

Self-Efficacy | Confidence Score

Name: _____

Date: _____

Instructions: After carefully reading each statement below, mark how confident are you that you could be physically active in each of the following situations?

Definitions:

Physical activity or exercise: includes such activities as walking briskly, jogging, bicycling, swimming, or any other activity in which the exertion is at least as intense as these activities.

Scale:

1: not at all confident 2: slightly confident 3: moderately confident 4: very confident 5: extremely confident

	1	2	3	4	5
1. When you are tired.					
2. When you are in a bad mood.					
3. When you feel you don't have time.					
4. When you are on vacation.					
5. When it is raining or snowing.					

Sources: Marcus BH, 1992; Marcus and Forsyth, 1992

Pros vs. Cons | Decisional Balance Score

Name: _____

Date: _____

Instructions: After carefully reading each statement below, please rate how important each statement was in your decision of whether or not to become more physically active. In each case, think about how you feel **right now**, not how you have felt in the past or would like to feel.

Definitions:

Regular physical activity or exercise: includes such activities as walking briskly, jogging, bicycling, swimming, or any other activity in which the exertion is at least as intense as these activities. To be regular, time spent exercising must add up to a total of 30 minutes or more per day and be done at least 5 days per week. For example, you could take one 30-minute walk, or take three 10-minute walks for a daily total of 30 minutes

Scale:

1: not at all important 2: slightly important 3: moderately important 4: very important 5: extremely important

	1	2	3	4	5
1. I would have more energy for my family and friends if I were regularly physically active.					
2. Regular physical activity would help me relieve tension.					
3. I think I would be too tired to do my daily work after being physically active.					
4. I would feel more confident if I were regularly physically active.					
5. I would sleep more soundly if I were regularly physically active.					
6. I would feel good about myself if I kept my commitment to be regularly physically active.					
7. I would find it difficult to find a physical activity that I enjoy & is not affected by bad weather					
8. I would like my body better if I were regularly physically active.					
9. It would be easier for me to perform routine physical tasks if I were regularly physically active.					
10. I would feel less stressed if I was regularly physically active.					
11. I feel uncomfortable when I am physically active because I get out of breath and my heart beats very fast.					
12. I would feel more comfortable with my body if I were regularly physically active.					
13. Regular physical activity would take too much of my time.					
14. Regular physical activity would help me have a more positive outlook on life.					
15. I would have less time for my family and friends if I were regularly physically active.					
16. At the end of the day, I am too exhausted to be physically active.					

Sources: Marcus BH, 1992; Marcus and Forsyth, 1992