TACTICAL WORKOUTS
FOR MILITARY OPERATORS AND LAW ENFORCEMENT PROFESSIONALS

Health History Questionnaire

First name _____ Date _____

Last name _____

Address 1 _____

Address 2 _____

City _____ State _____ Zip _____

Phone 1 _____ Phone 2_____

Email 1 _____

Email 2 _____

Date of birth_____ Age_____

Height _____ Weight_____

Person to contact in case of emergency:

Name_____ Phone _____

For most people, physical activity should not pose any problem or hazard. The following questions are designed to identify the small number of adults for whom physical activity might be inappropriate or those who should have medical advice concerning the type of activity most suitable for them.

Common sense is your best guide in answering these questions. Please read them carefully and check the "Yes" or "No" response opposite the question if it applies to you.

Yes	No	
___	___	1. Has your doctor ever said you have heart trouble? If yes, please describe the problem and state when it was diagnosed.
		_____
		_____
___	___	2. Do you frequently have pain in your heart or chest?
___	___	3. Do you often feel faint or have spells of severe dizziness?
___	___	4. Has a doctor ever told you that your blood pressure was too high?

___ ___ 5. Has your doctor ever told you that you have a bone or joint problem, such as arthritis, that has been aggravated by exercise or might be made worse by exercise?

___ ___ 6. Is there a good physical reason not mentioned here why you should not follow an activity program even if you wanted to do so?

___ ___ 7. Are you over age 65 and/or not accustomed to vigorous exercise?

___ ___ 8. Are you or have you ever been a diabetic?

___ ___ 9. Are you now pregnant, or have you been pregnant within the last 3 months?

___ ___ 10. Have you had any surgery in the last 3 months?

___ ___ 11. Have you been hospitalized in the last 2 years? If yes, when and why?

_____

___ ___ 12. Have you ever seen a chiropractor, acupuncturist, or other alternative medicine practitioner? If yes, when and why?

_____

Please check the box if you have ever experienced any of the following symptoms:

	When first experienced	Treatment used
☐ Pain or discomfort in the chest	_____	_____
☐ Unaccustomed shortness of breath	_____	_____
☐ Dizziness	_____	_____
☐ Labored or uncomfortable breathing, with or without pain	_____	_____
☐ Swollen ankles	_____	_____
☐ Heart palpitations	_____	_____
☐ Heart murmur	_____	_____
☐ Limping	_____	_____

☐ Yes ☐ No Do you have high blood pressure? If yes, what is your current blood pressure without medication?

_____

☐ Yes ☐ No Are you taking any medication for hypertension? If so, what medication?

_____

☐ Yes ☐ No Is your total serum cholesterol level over 240?

☐ Yes ☐ No Do you currently smoke?

☐ Yes ☐ No Have you ever smoked? If so, when did you quit?

☐ Yes ☐ No Do you have diabetes?

☐ Yes ☐ No Do you have a family member who has had coronary or atherosclerotic disease before age 55?

☐ Yes ☐ No Do you have pain or discomfort in your back? If yes, indicate q cervical ☐ thoracic ☐ lumbar ☐ sacral ☐ coccygeal?

☐ Yes ☐ No Do you have pain or discomfort in your shoulder? If yes, ☐ right or ☐ left?

☐ Yes ☐ No Do you have pain or discomfort in your elbow? If yes, ☐ right or ☐ left?

☐ Yes ☐ No Do you have pain or discomfort in your wrist/hand? If yes, ☐ right or ☐ left?

☐ Yes ☐ No Do you have pain or discomfort in your hip? If yes, ☐ right or ☐ left?

☐ Yes ☐ No Do you have pain or discomfort in your knee? If yes, ☐ right or ☐ left?

☐ Yes ☐ No Do you have pain or discomfort in your ankle/foot? If yes, ☐ right or ☐ left?

If you checked "Yes" above, please describe your pain. On a scale of 1 to 10, with 1 being almost nonexistent and 10 being excruciating, how severe is it? Does it get more or less severe as the day goes on? When do you notice it? What really aggravates it?

_____

_____

☐ Yes ☐ No Have you ever torn ligaments or cartilage in your knee? If yes, when? _____

Did you have surgery on this knee? If yes, when? _____

☐ Yes ☐ No Have you ever dislocated your shoulder? If yes, when?

_____

☐ Yes ☐ No Have you ever had shoulder surgery? If yes, which shoulder? When?

_____

☐ Yes ☐ No Have you ever had a neck injury, such as whiplash? If yes, when?

_____

☐ Yes ☐ No Have you ever been treated for a spinal disk injury? If yes, when?

_____

☐ Yes ☐ No Do you ever experience tingling or numbness in your elbows or hands?

_____

What is the present state of your general health? _____

What regular physical activities do you follow now? _____

How often? _____ For how long each session? _____

How did you learn about us? _____

I, _____, certify that I understand the foregoing questions and my answers are true and complete. I also understand that this information is being provided as part of my initial consultation and may not be periodically updated.

I, _____, assume the risk for any changes in my medical condition that might affect my ability to exercise.

_____ _____
Signature Date

_____
Please print name

If you answered yes to one or more questions and you have not recently consulted with your doctor, do so before beginning an exercise program. Tell your doctor which questions you answered yes to and explain that you plan to undergo an exercise program that may include, but may not be limited to, dynamic warmup activity, reactive training, resistance training, core/balance exercise, cardiorespiratory training, and recovery exercise. After medical evaluation, ask your doctor

1. which activities you may safely participate in, and
2. what specific restrictions, if any, should apply to your condition and which activities and/or exercises you should avoid.

I, _____, acknowledge that I have read the foregoing statements and understand the content thereof.

_____ _____
Signature Date

_____
Please print name

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Goal Inventory

Client _____ Date _____

1. What I want to accomplish.
   These are my outcome goals for the next 12 weeks:

2. Why I want to accomplish these goals.
   These goals are very important to me because:

3. My healthy lifestyle plan for achieving these goals.
   Describe your 1) training, 2) nutrition, 3) sleep, and 4) stress management strategies:

4. "I think that my exercising at least 4 days a week, every week, is highly likely." Please circle the number of the answer that best describes your response to this statement.

   1 Strongly agree

   2 Agree

   3 Disagree

   4 Strongly disagree

   If you circled 3 or 4, why? (Please be as specific as possible.)

5. When I reach this goal, here's what I will get and how I will feel:

Lifestyle Questionnaire

Your Attitude Toward Food

Diets

Have you ever been on a diet? If so, please answer the following questions:

How many diets have you been on in the last 2 years? _____

Describe any diets you've been on. Did you go to a commercial weight-loss service (Jenny Craig, Diet Center, etc.)? Did you follow a diet from a book or article? If so, which one?

_____

_____

Describe your experience with diets. Did you lose weight? Did you gain any of it back?

_____

_____

Food

☐ Yes ☐ No Do you eat breakfast?

☐ Yes ☐ No Typically, do you eat after 8 p.m.? If so, what do you usually eat?

_____

How many times a day do you eat?

_____

☐ Yes ☐ No Can you recall ever eating to avoid doing something? If so, when was this?

_____

☐ Yes ☐ No Do you ever eat when you aren't hungry? If so, when?

_____

How often do you read food labels?

_____

☐ Yes ☐ No Do you ever "treat" yourself with food? If so, when?

_____

What sources of information about nutrition have you found most helpful?

_____

☐ Yes ☐ No Has someone ever encouraged you to eat something that is not in your best interest? If yes, did you do it? Why?

_____

Your Attitude Toward Exercise: What's the Point of All of This, Anyway?

You need to create a clear, tangible image in your mind of the benefits of staying on your fitness program. It must be vivid and powerful enough to sustain you through difficult times when you feel your self-discipline and motivation slipping. This exercise will help you create that image.

Complete this sentence: "Doing three cardiovascular exercise sessions and two to three resistance training sessions per week will . . ."

	Not likely					Very likely
Improve my appearance	1	2	3	4	5	6
Allow me to cope with stress better	1	2	3	4	5	6
Help me avoid getting sick	1	2	3	4	5	6
Give me a powerful sense of personal achievement	1	2	3	4	5	6
Increase my self-esteem	1	2	3	4	5	6
Improve my physical strength	1	2	3	4	5	6
Make me more independent	1	2	3	4	5	6
Improve my ability to concentrate	1	2	3	4	5	6
Take up too much time	1	2	3	4	5	6
Cause pain, soreness, and discomfort	1	2	3	4	5	6
Make me very tired	1	2	3	4	5	6
Cause me to get injured	1	2	3	4	5	6

Please rewrite this sentence and complete it in your own words.

Doing three cardiovascular sessions and two to three resistance training sessions per week will . . .

_____

_____

Do you need support from others (friends, family, etc.) to stay consistent with your exercise and nutrition program? ☐ Yes ☐ No Do you have this type of support? ☐ Yes ☐ No

On a scale of 1 to 10 (with 10 being the ultimate nurturing, supportive group), how would you rate your support from others? _____

Are there people in your life who either intentionally or unintentionally discourage you or interfere with your staying consistent in your exercise and/or nutrition program? ☐ Yes ☐ No If yes, how do they interfere? How do you deal with it?

_____

Has someone else ever interfered with your choice to exercise? ☐ Yes ☐ No If yes, what happened?

If you answered yes to questions 3 or 4, how have you dealt with these situations in the past? What are your thoughts about how to improve these responses in the future?

	Not likely					Very likely
I think it is very likely that I will exercise four times per week.	1	2	3	4	5	6
I think exercise is a waste of time for me.	1	2	3	4	5	6
I know that I will be consistent with my fitness and nutrition program for 12 months.	1	2	3	4	5	6
When I exercise, I am self conscious of the way I look.	1	2	3	4	5	6
When I exercise, I always feel exhausted afterward.	1	2	3	4	5	6

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PHYSICIAN REFERRAL AND CLEARANCE FOR EXERCISE

PATIENT INFORMATION

NAME

HOME PHONE | CELL PHONE | DOB

PHYSICIAN INFORMATION & REFERRAL

PHYSICIAN NAME | PHONE NUMBER

REASON FOR REFERRAL

- ☐ AIDS
- ☐ Anemia
- ☐ Aneurysms
- ☐ Angina & Silent Ischemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Cancer
- ☐ Cardiac Transplant
- ☐ Cerebral Palsy
- ☐ Chronic Fatigue Syndrome
- ☐ Chronic Heart Failure
- ☐ Childhood Obesity
- ☐ Coronary Artery Bypass Graft
- ☐ Cystic Fibrosis
- ☐ Deaf & Hearing Impaired
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fibromyalgia
- ☐ Frailty
- ☐ Hyperlipidemia
- ☐ Hypertension
- ☐ Lower Back Pain Syndrome
- ☐ Lower-Limb Amputation
- ☐ Mental Illness
- ☐ Mental Retardation
- ☐ Multiple Sclerosis
- ☐ Muscular Dystrophy
- ☐ Myocardial Infarction
- ☐ Obesity
- ☐ Orthopedic
- ☐ Osteoporosis
- ☐ Pacemakers
- ☐ Parkinson's Disease
- ☐ Peripheral Arterial Disease
- ☐ Polio & Post-Polio Syndrome
- ☐ Stress
- ☐ Stroke
- ☐ Valvular Heart Disease
- ☐ Visual Impairment
- ☐ Other _____

PHYSICIAN CLEARANCE

- ☐ Patient is cleared to participate in graded exercise testing and exercise programming
- ☐ Patient must have diagnostic stress test prior to exercise.
- ☐ Additional medical concerns or restrictions to exercise programming:

PHYSICIAN SIGNATURE | DATE