



Exercise History Questionnaire

Patient Name _____ Date _____

1. Have you been cleared for exercise? Yes No

2. What are you doing on a regular basis that gets you moving and gets your heart rate up?

Cardio/Aerobic exercise: (e.g., walking, jogging, running, dancing)

Activity 1 _____ x per week for _____ minutes

Activity 2 _____ x per week for _____ minutes

Strength/Resistance exercise: (e.g., resistance machines, kettle bell, pilates, weightlifting)

Activity 1 _____ x per week for _____ minutes

Activity 2 _____ x per week for _____ minutes

Flexibility/Stretching exercise: (e.g., yoga, pilates, matwork, stretches)

Activity 1 _____ x per week for _____ minutes

Activity 2 _____ x per week for _____ minutes

Balance exercise: (e.g., tai chi, qi gong, bosu ball, dancing)

Activity 1 _____ x per week for _____ minutes

Activity 2 _____ x per week for _____ minutes

3. How do you monitor your exercise intensity?

<input type="checkbox"/> General Intensity	<input type="checkbox"/> Talk Test	<input type="checkbox"/> Perceived Exertion	<input type="checkbox"/> Heart Rate*
Light	Able to talk and/or sing	< 3 (10 point scale)	< 64% HR _{max}
Moderate	Able to talk but not sing	3-4 (10 point scale)	64-76% HR _{max}
Vigorous/hard	Difficulty talking	≥ 5 (10 point scale)	>76% HR _{max}

4. Are you satisfied with your current exercise program? Yes No

If no, explain _____

5. What are your motivators for exercise? (Check all that apply)

- Prevent cardiac disease and stroke
- Reduce blood pressure
- Control blood glucose
- Prevent bone loss
- Increase energy
- Increase self esteem
- Improve mood
- Decrease stress
- Improve sleep
- Weight reduction
- Increase mental alertness
- Better endurance
- Increase interest in sex
- Other _____

6. What types of aerobic exercise do you prefer? (Circle all that apply)

Walking, hiking, blading, jogging, treadmill, bicycling indoors/outdoors, EFX elliptical, stair climbers, swimming, rowing, water aerobics, aerobics classes, cross country skiing, downhill skiing/snowboarding, snowshoeing, other _____

7. What do you like most about exercising?

*Not an appropriate measure of intensity if taking a Beta Blocker

EXERCISE HISTORY QUESTIONNAIRE

8. Do you have an exercise partner? Yes No

9. Do you enjoy group exercise or classes? Yes No

10. Are you a member of a gym or fitness center? Yes No

11. Are there any obstacles you have to engaging in movement and physical activity? Yes No

a. If yes, what are they?

b. If yes, do you have control over the circumstances surrounding your obstacles? How can you overcome them?

c. Are any of your obstacles out of your control? If yes, which ones?

d. What are some possible solutions around these obstacles? What has worked before?

12. What is the best time of day for you to exercise? _____

13. When do you have the most energy and time? _____

14. Are you ready to take action to make your exercise program work for you and your goals? Yes No

15. Do you have any goals related to you strength, tone, body composition, or fitness level? Yes No

If yes, explain: _____

16. Do you experience any pain or breathing problems while exercising? Yes No

If yes, explain: _____

17. Do you have any joint or musculoskeletal problems that might flare up during exercise? Yes No

If yes, explain: _____

18. Have you had any injuries while exercising? Yes No

If yes, explain: _____

19. Have you experienced a loss of muscle tissue or a decline in strength over the last few years? Yes No

20. Have you fallen in the past few months? Yes No

21. Do you notice any balance problems? Yes No

If yes, explain: _____

22. Do you have any of the following exercise contraindications? (Check all that apply)

Acute systemic infection (i.e., fever, body aches, swollen lymph nodes, etc.)

Arrhythmias

Recent heart attack

Severe congestive heart failure

Uncontrolled angina/chest pain

Other _____

