

Office on Women's Health (OWH)

Living Healthier, Living Longer

Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

What is the best phone number at which to reach you? \_\_\_\_\_

ZIP code of residence \_\_\_\_\_

In case of emergency, please contact \_\_\_\_\_

At (insert phone number(s)): \_\_\_\_\_

### **Background and General Health History**

1. Do you have any kind of health care coverage, including health insurance, prepaid plans such as HMOs, or government plans such as Medicare?

- No
- Yes

2. Have you had at least one menstrual period in the past 12 months? (Please do not include bleedings caused by medical conditions, hormone therapy, or surgeries.)

- No
- Yes
- N/A

3. Have you smoked at least 100 cigarettes in your lifetime? (NOTE: 5 packs = 100 cigarettes)

- No (*skip to question 5*)
- Yes
- Don't know/Not sure

4. Do you NOW smoke every day, some days or not at all?

- Every day
- Some days
- Not at all
- Don't know/Not sure

5. Do you have any dietary restrictions or preferences?

- None
- Gluten-free
- Vegetarian
- Vegan
- Lactose free
- Other (please explain) \_\_\_\_\_

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6. Do you currently have or have a history of (check all that apply):

- |   |   |
|---|---|
| <input type="checkbox"/> Diabetes   | <input type="checkbox"/> Chest discomfort with exertion                               |
| <input type="checkbox"/> High blood pressure  | <input type="checkbox"/> Dizziness, fainting, or blackouts                            |
| <input type="checkbox"/> Asthma or other lung disease   | <input type="checkbox"/> Shortness of breath at rest or with mild exertion            |
| <input type="checkbox"/> Pain in the legs that causes you to stop walking   | <input type="checkbox"/> Labored breathing at rest or with mild exertion              |
| <input type="checkbox"/> Other conditions (mitral valve prolapse, epilepsy, rheumatic fever, etc.) that may hinder your ability to exercise | <input type="checkbox"/> Unusual fatigue or shortness of breath with usual activities |
|   | <input type="checkbox"/> NONE OF THE ABOVE  |

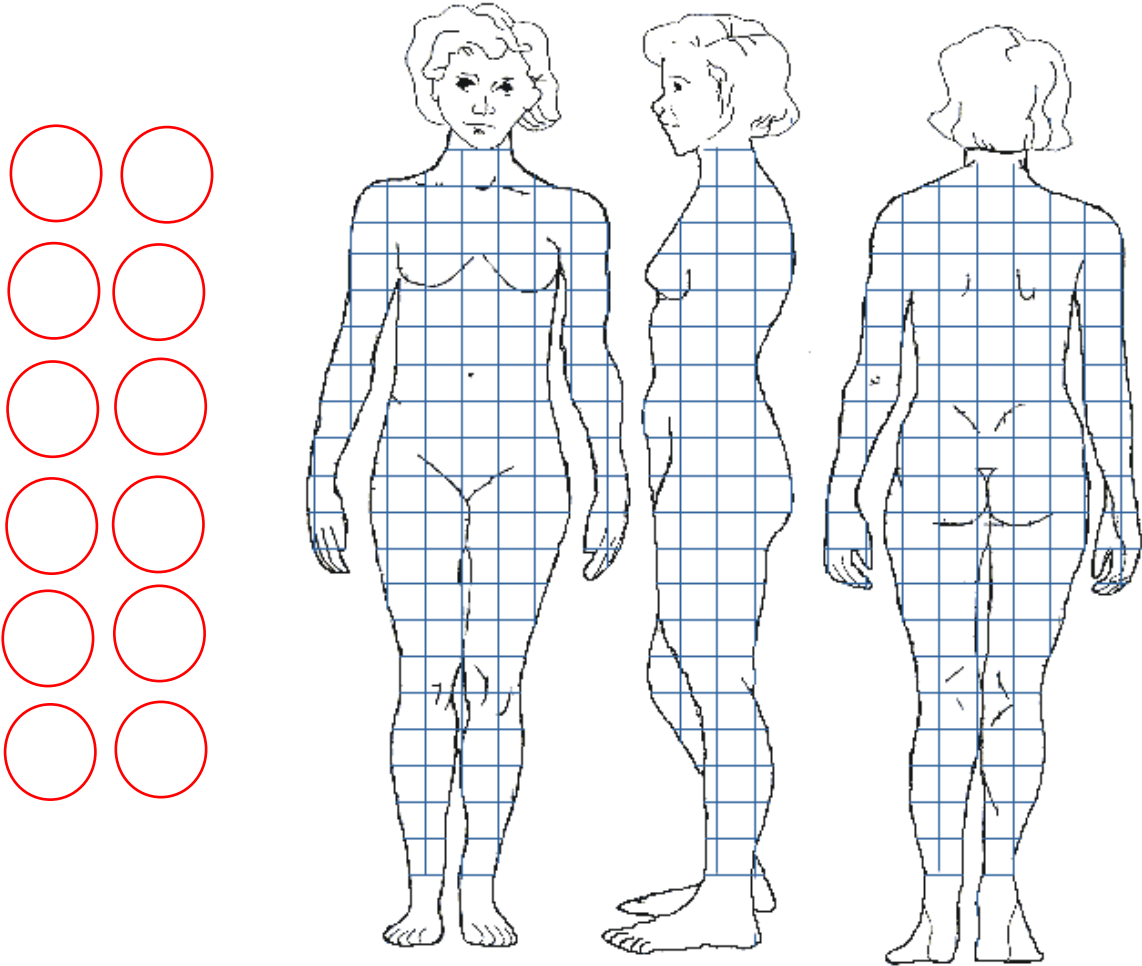
7. Do you have a long-term physical or mental impairment that substantially limits one or more major life activities?

- No (*skip to question 9*)  
 Yes

8. In which activities are you limited (*only respond if you answered "Yes" to question 7*)?

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Caring for myself       | <input type="checkbox"/> Lifting or reaching                | <input type="checkbox"/> Learning, thinking or concentrating |
| <input type="checkbox"/> Performing manual tasks | <input type="checkbox"/> Seeing                             | <input type="checkbox"/> Working                             |
| <input type="checkbox"/> Walking or standing     | <input type="checkbox"/> Hearing, speaking or communicating | <input type="checkbox"/> Other (please explain) _____        |

9. Using the circles on the left (click and drag), please add a circle to any areas of pain, injury, tension, or restriction of movement.



10. If you circled any areas of pain, tension, or restriction of movement, please explain here:

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11. Which of the following describes your previous attempts to lose weight (select all that apply)







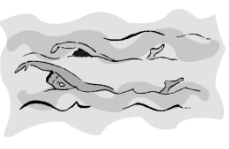



- I have never tried to lose weight
- I have tried to lose weight by exercising
- I have tried to lose weight by dieting
- I have tried to lose weight with the aid of weight loss pills
- I have tried to lose weight with the aid of surgery
- Other (please explain)\_\_\_\_\_)

12. Do you have any of the following negative feelings toward any exercise or exercise program *the majority of the time*? Please select all that apply.

- I have no negative feelings toward exercise or exercise programs
  - Sweat makes me feel uncomfortable
  - I am uncomfortable in a gym
  - Exercise bores me
  - Exercise is exhausting
  - The information available about exercise is confusing
  - I feel as though I do not benefit from exercise
  - Exercise is too time-consuming
  - Exercise programs are expensive
  - I have been unsuccessful with previous exercise efforts
  - Other (please explain)\_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

**Current Physical Activity**

For questions 13 – 19, we are interested in your physical activity. Physical activities are activities where you move and increase your heart rate above its resting rate, whether you do them for pleasure, work, or transportation. *Please refer to the following graphic for examples of physical activity intensity levels:*

<p><b><u>LIGHT</u></b> activities</p> <ul style="list-style-type: none"> <li>Your heart beats slightly faster than normal</li> <li>You can talk and sing</li> </ul>	 Walking leisurely	 Stretching	 Vacuuming; light yard work	
<p><b><u>MODERATE</u></b> activities</p> <ul style="list-style-type: none"> <li>Your heart beats faster than normal</li> <li>You can talk but not sing</li> </ul>	 Fast walking	 Aerobics class	 Strength training	 Swimming gently
<p><b><u>VIGOROUS</u></b> activities</p> <ul style="list-style-type: none"> <li>Your heart rate increases a lot</li> <li>You can’t talk or your talking is broken up by large breaths</li> </ul>	 Stair machine	 Jogging or running	 Tennis, racquetball, or badminton	

13. During the last 7 days, on how many days did you do **vigorous** physical activities? *Vigorous activities are activities during which your heart rate increases a lot and you can’t talk (or talking is broken up by taking large breaths).*

\_\_\_\_\_ days per week

No vigorous physical activities (*skip to question 15*)

14. How much time did you usually spend doing **vigorous** physical activities on one of those days?

\_\_\_\_\_ hours per day      or      \_\_\_\_\_ minutes per day

Don't know/not sure

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15. During the last 7 days, on how many days did you do **moderate** physical activities? **Do not include walking.** *Moderate activities are activities during which your heart beats faster than normal and you can talk but not sing.*

\_\_\_\_\_ days per week

No moderate physical activities (*skip to question 17*)

16. How much time did you usually spend doing **moderate** physical activities on one of those days?

\_\_\_\_\_ hours per day      *or*      \_\_\_\_\_ minutes per day

Don't know/not sure

17. During the last 7 days, on how many days did you walk for at least 10 minutes at a time? *Only include those instances where you walked continuously for at least 10 minutes.*

\_\_\_\_\_ days per week

No walking (*skip to question 19*)

18. How much time did you usually spend walking on one of those days?

\_\_\_\_\_ hours per day      *or*      \_\_\_\_\_ minutes per day

Don't know/not sure

19. During the last 7 days, how much time did you spend sitting on a weekday? *Remember to include time spent sitting at home, at work, in your leisure time, or in a car.*

\_\_\_\_\_ hours per day      *or*      \_\_\_\_\_ minutes per day

Don't know/not sure

**Goals**

20. Select all of the goals that are most important to you with your participation in this program:

- Improve overall health
- Improve endurance
- Improve balance/coordination
- Improve exercise knowledge
- Improve nutritional knowledge
- Reduce stress
- Increase energy
- Increase flexibility
- Increase strength
- Have fun/socialize
- Lose weight (\_\_\_\_\_ pounds)
- Other (\_\_\_\_\_)

21. On a scale of 1-10, with 10 being 100 percent ready to take action, how ready are you to make lifestyle changes to improve your health?

- 1
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9
- 10

22. What factors might keep you from reaching your health and fitness goals?

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**Please take a moment to carefully read the following information and sign where indicated.**

I acknowledge that I have voluntarily chosen to participate in a nutrition and physical activity program, and that the nutrition and exercise information I receive is provided for the purpose of instruction and guidance. I further understand that personal trainers, nutritional consultants, and other instructors involved in this program are not qualified to perform, diagnose, or treat any physical or mental illness, and that nothing said in the course of this program should be considered as such. I fully understand that I may injure myself as a result of my participation in this program and I hereby release The Office on Women's Health, The Lewin Group, and SAGE and (and all staff and affiliates) from any liability now or in the future for conditions that I may obtain. These conditions may include, but are not limited to, heart attacks, muscle strains, muscle pulls, muscle tears, broken bones, shin splints, heat prostration, injuries to knees, injuries to back, injuries to foot, allergic reaction, or any other illness or soreness that I may incur, including death. Additionally, I understand that I am responsible for monitoring my own condition throughout the exercise program.

Note: To reduce the risk of any injury and /or illness, before beginning this or any nutrition and physical activity program, please seek medical advice for guidance regarding appropriate dietary changes, exercise levels and precautions. It is particularly important to seek such advice if you suffer from an ongoing medical condition which may be affected by change in diet or exercise. The nutrition and exercise instruction and advice presented is for information purposes only and is in no way intended as a substitute for medical consultation. The Office on Women's Health, The Lewin Group, and SAGE accept no liability from and in connection with this program.

**By signing this document, I assume all risk for my health and well-being and hold harmless of any responsibility, The Office on Women's Health, The Lewin Group, and SAGE, and affirm that I have read and fully understand the above statements.**

Signature\_\_\_\_\_

Date\_\_\_\_\_

***End of Questionnaire***