Carolinas Weight Management and Wellness Center
Patient Exercise Evaluation Questionnaire

Name: ________________________________ Date: ___________ Age: _______ Date of Birth: ___________

Gender: _______ Height: _________ Weight: _________ BMI: _________

Address: ____

Phone: (H) _____________ (w) _____________ (cell) _____________ Email: ______________________

Insurance Provider: _____________________________ Occupation: _________________________________

Have you had a stress test in the last year? ________ Have you lost weight in the last 6 months? ________

Exercise and Activity Experience (*please check all that apply)*

1. Are you currently active? ❑Yes ❑No

2. If yes, what type(s) of exercise are you doing?
- ❑Walking (treadmill or outside)
- ❑Bicycling (stationary or outside)
- ❑Elliptical Machine
- ❑Strength training with weights
- ❑Swimming or Water Exercise Classes

3. How many times per week do you exercise? ❑1-2 days ❑3-4 days ❑5-6 days ❑Everyday

4. How long is each exercise session? ❑Less than 30 minutes ❑30-60 minutes ❑Longer than 60 minutes

5. If the answer to question #1 was No, when were you last physically active and what activities did you enjoy?
____

6. What barriers stand in your way when you consider exercising? ______________________________
____

7. Do you need assistance with ambulation? ❑Yes ❑No If yes, what aids do you utilize to assist you? (Cane, walker, motorized cart, other) ____

8. Do you experience shortness of breath while walking? ❑Yes ❑No If yes, after how long? ❑0-10 minutes ❑10-20 minutes ❑20-30 minutes ❑After 30 minutes

9. Do you have joint or other issues that cause pain or limited movement when performing activities of daily living or exercising? ❑Yes ❑No If yes, please describe ______________________________
____

10. Do you have trouble getting down onto and up from the floor? ❑ Yes ❑No

11. Are you able to walk up a flight of stairs? ❑Yes ❑No

12. Willingness and level of commitment to exercise in order to create and maintain a healthy lifestyle. (1-10 scale)
Additional comments: ____
____

Carolinas Weight Management
& Wellness Center

FITNESS EVALUATION FORM

CWM-209 (2/08)

Patient Information Sticker

Name:

DOB:

Medical Record#:

Job: CL8174
CWM-209
1st proof: 2/19/08
FACE
Ink: BLACK
Paper: 20# White

Workflow One

Fitness Goals:

Do you currently have any fitness related goals? ❑Yes ❑No

If so, please list or describe them:

___

___

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For Staff Use:

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Patient Information Sticker

Name:

DOB:

Medical Record#:

Job: CL8174
CWM-209
1st proof: 2/19/08
BACK (Head to tumble)
Ink: BLACK
Paper: 20# White

WorkflowOne