Pre-Screen Questionnaire

Employee Name: ______________________________ Date of Birth: ______________

Phone: ______________________ Email: ______________________________

Employer: ______________________ Area: ______________________

Medical History Assessment

Cardiac History

- Myocardial Infarction
- Cerebral Vascular Accident
- CABG
- PTCA/Stent
- Valve Replacement/Repair
- Atrial Fibrillation
- Pacemaker/ICD
- Other:
  ____

Cardiac RISK FACTORS

- Hypertension
- Dyslipidemia
- Inactivity
- Diabetes (Type I / Type II)
- Depression/Anxiety
- Tobacco Use:
  Packs/Yrs.______________
- Obesity
- Stress
- Family History

Pulmonary History

- Asthma
- COPD
- Other:
  ____

Medications: Medication/ Dosage

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

Exercise History

Type: ______________________________ ____________________________________

____

Duration: __________________________

Frequency: __________________________

Musculoskeletal History: (Injuries/Areas of Pain/Discomfort that limit activities of daily living (ADLS) and exercise.)

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____

Nutrition Assessment

Goals:

1. ____
2. ____
3. ____

Barriers:

1. ____
2. ____
3. ____
4. ____

Previous Weight Loss Methods: ____

Do you Skip Meals? YES No

How many Meals & Snacks/Day? ______________

Who does most of the grocery shopping? Self Spouse Other: _______________

Who does most of the cooking? Self Spouse Other: _________________

Do you read nutrition labels? YES No

If yes, what do you focus on? Calories Fat CarbohydratesProtein Sodium

How many times do you eat at a restaurant? ________ Per/Week

How many times do you eat at a fast-food restaurant? _________ Per/Week

Allergies/Intolerances: Yes No

Foods Avoid/Dislike: ____

Alcohol Beverages: _______________ Per/Week

Caffeinated Beverages: _______________ Per/Day

Water Consumption: _______________ Per/Day

Vitamins/Supplement: Yes No (If answered Yes, Please list below)

____

Dietary Recall

Weekday

Wake: _______________ AM/PM

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Bed: _______________ AM/PM

Weekend

Wake: _______________ AM/PM

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Bed: _______________ AM/PM

ASSESSMENT

TREATMENT PLAN/RECOMMENDATIONS:

- Education on My Plate
- Education on Protein/Carbohydrates/Fats
- Education on Nutrition & Diabetes
- Education on Nutrition & Heart Disease
- Meal Planning Education/Develop Custom Meal Plan
- Nutrition Recall and Review for next appointment
- Complete & Review Body Composition Assessment
- Provide information regarding State Tobacco Cessation Programs (Ohio & WV)
- Schedule for Tobacco Cessation Counseling
- Schedule and Complete Exercise Rx.
- Other: ______________________________

Next Scheduled Appointment: ______________________________

______________________________ ______________

Clinical Signature Date