LAKESHORE

Name: _____

Date of Birth: _____

Readiness Questionnaire

This questionnaire will help us guide you to programs that may be most appropriate for you. Before becoming more physically active or if your health changes, we encourage you to speak to your doctor about any recommendations, contraindications, physical limitations or restrictions you may have.

		YES	NO
1.	Has your doctor ever said that you should only do medically supervised physical activity?	☐	☐
2.	Are you currently going to physical therapy or have active physical therapy orders from a physician?	☐	☐
3.	Do you currently have or have had any bone or joint problems, or orthopedic surgeries that might limit you from engaging in physical activity?	☐	☐
4.	Do you have arthritis, osteoporosis, or back problems?	☐	☐
5.	Do you currently have cancer of any kind? If yes, please specify.	☐	☐
6.	Do you have a heart or cardiovascular condition? (i.e. Coronary Artery Disease, Heart Failure, or a diagnosed heart rhythm abnormality)	☐	☐
7.	Do you currently have high blood pressure? If yes, do you have difficulty managing your condition with medication or other physician-prescribed treatments? ☐ Yes ☐ No	☐	☐
8.	Do you have any metabolic conditions? (i.e. Diabetes or pre-diabetes, chronic kidney disease or liver problems). If yes, do you have difficulty managing your condition with medication or other physician-prescribed treatments? ☐ Yes ☐ No	☐	☐
9.	Do you have a respiratory disease? (i.e. Chronic Obstructive Pulmonary Disease, Asthma, Pulmonary High Blood Pressure, Emphysema) If yes, please specify. Please select from the following	☐	☐
10.	Do you have a spinal cord injury? If yes, do you have ☐ paraplegia or ☐ quadriplegia? Date of injury: _____	☐	☐
11.	Have you had a stroke? If yes, how affected? Date of injury: _____	☐	☐

		YES	NO
12.	Do you use a mobility device to get around inside the home or in the community? If yes, what type of device? ○ Manual Wheelchair ○ Power Wheelchair ○ Walker/Rollator ○ Cane/Crutches ○ Other	○	○
13.	Do you have any other medical condition not listed above? If yes, please check the box(es) below that apply to your health.	○	○
	☐ Amputation Type: _____ Prosthesis: ○ Yes ○ No		
	☐ Ankylosing Spondylitis ☐ Ataxia		
	☐ Blind or Low Vision - Requires assistance with community mobility: ○ Yes ○ No		
	☐ Cerebral Palsy		
	☐ Epilepsy or Seizure Disorder If yes, have you had a seizure in the past 6 months? ○ Yes ○ No		
	☐ Head Injury - Date of Onset: _____		
	☐ Lymphedema ☐ Morbid Obesity		
	☐ Multiple Sclerosis ☐ Muscular Dystrophy		
	☐ Neuropathy ☐ Osteogenesis Imperfecta		
	☐ Parkinson's Disease ☐ Post-Polio Syndrome		
	☐ Spina Bifida ☐ Spinal Muscular Atrophy		
	☐ Other Not Listed – Specify: _____		
14.	Do any of the following apply to you: ○ Incontinence of bowel or bladder ○ Current pressure sore(s) ○ On a bowel management program ○ Current open wound(s) ○ History of gastrointestinal (GI) issues such as irritable bowel syndrome (IBS), C-Diff, Chron's, Colitis, etc.		
15.	In case of emergency, is there any information you would want shared with emergency personnel? (i.e. allergies, hospital preference)		
16.	Are you comfortable using the aquatics center independently and safely?	○	○
17.	Are you comfortable using the fitness center equipment independently and safely?	○	○
18.	Do you prefer to have a one-time complimentary session to get you started?	○	○
19.	If yes, in what area(s)? ○ Aquatics Center ○ Fitness Center ○ Both		
20.	Are you interested in meeting with someone from the Recreation and Athletics department to learn more about programs offered?	○	○

I have fully read, understood, and completed this questionnaire. I agree that I have been encouraged by the Lakeshore Foundation staff to seek advice from my doctor before becoming more physically active, or if my health changes.

Signature: _____ Date: _____