PACIFIC BRAIN HEALTH CENTER

AT PACIFIC NEUROSCIENCE INSTITUTE℠

Health and Exercise Questionnaire

Patient Name_____ Date _____

DOB_____ Physician _____

Have you been cleared for exercise?
☐ Yes ☐ No

Have you ever worked with a health and fitness professional?
☐ Yes ☐ No

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

Do you take group exercise or activity classes?
☐ Yes ☐ No

Are you comfortable using computer-based or app-based training for cognitive training or physical training?
☐ Yes ☐ No

Do you have any musculoskeletal or pain issues?
☐ Yes ☐ No

Do you have any noticeable balance issues?
☐ Yes ☐ No

Have you sustained any falls recently?
☐ Yes ☐ No If yes, explain _____

Have you ever sustained a hit to the head, a concussion, or a traumatic brain injury?
☐ Yes ☐ No If yes, explain _____

Do you have issues falling asleep or staying asleep?
☐ Yes ☐ No

Do you use sleeping aids?
☐ Yes ☐ No If yes, list _____

Do you have any issues that limit exercise or physical activity?
☐ Yes ☐ No If yes, explain _____

Do you use relaxation techniques (meditation, mindfulness, breathing, prayer, etc)?
☐ Yes ☐ No

1301 20th St. #145, Santa Monica, CA 90404
Phone 310-582-7641 | Fax 310-315-4069 | www.pacificbrainhealth.org