

FITNESS ASSESSMENT QUESTIONNAIRE

Title 32-AGR - Traditional

PRIVACY ACT STATEMENT

AUTHORITY: 10 USC 8013 & EO 9397

PRINCIPLE PURPOSE. To process members into and through the Air National Guard Fitness Program. SSN is collected to identify the ANG Member in the ANG Fitness Program database.

ROUTINE USE: None.

DISCLOSURE: Voluntary. Failure to furnish information will not change your requirement to participate in the Air National Guard Fitness Program.

Today's Date: _____

Name: _____ Rank: _____ Male Female

SSN: _____ Date of Birth: _____ Traditional Title 32-AGR

Assigned Unit: _____ Wing (or equivalent): _____ AFSC: _____

Email Address: _____

Please use an address that you check frequently. Can be non-military.

DO I QUALIFY FOR THE 1.5 MILE RUN?

IF YOU ANSWER **YES** TO ANY OF THESE QUESTIONS, YOU WILL PERFORM THE STEP TEST TO MEASURE YOUR CARDIO FITNESS AND **NOT** PERFORM THE 1.5 MILE RUN.

	YES	NO
Do you have a family history of heart disease?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have cholesterol over 200 (documented within the last 12 months) or do you not know your cholesterol?	<input type="checkbox"/>	<input type="checkbox"/>
Are you a male with a waist measurement over 40"?	<input type="checkbox"/>	<input type="checkbox"/>
Are you a female with a waist measurement over 35"?	<input type="checkbox"/>	<input type="checkbox"/>
Have you smoked cigarettes in the last 30 days?	<input type="checkbox"/>	<input type="checkbox"/>
I have not run frequently during the past 3 months. (not run vigorously for 30 minutes, at least 3 times per week)	<input type="checkbox"/>	<input type="checkbox"/>

PHYSICAL ACTIVITY READINESS QUESTIONS

	YES	NO
* Have you ever been diagnosed with a heart condition?	<input type="checkbox"/>	<input type="checkbox"/>
* Do you have chest pain brought on by physical activity?	<input type="checkbox"/>	<input type="checkbox"/>
* Do you feel light-headed or dizzy when exercising?	<input type="checkbox"/>	<input type="checkbox"/>
* Do you have any bone or joint problems or injuries?	<input type="checkbox"/>	<input type="checkbox"/>
* Are you taking any prescribed medications that could affect you during exercise (women: excludes birth control)?	<input type="checkbox"/>	<input type="checkbox"/>
* Are you pregnant or nursing (women only)?	<input type="checkbox"/>	<input type="checkbox"/>
* Are you aware of any reason against exercising without medical supervision?	<input type="checkbox"/>	<input type="checkbox"/>

If you answered, "Yes" to any question above (marked with an *), please notify the Unit Fitness Program Manager before the assessment begins.

If you completed these questions prior to today, please ensure that your answers are still correct.

HEALTHY HABIT QUESTIONS

	YES	NO		
Do you smoke or use tobacco?	<input type="checkbox"/>			
Are you a member of a health club?	<input type="checkbox"/>			
How many times do you exercise in a typical week?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	0	1-2	3-4	5-7

ASSESSMENT SCORES

Height: feet inches

Waist: 1/4 1/2 3/4 inches

Weight: pounds

Run Time: minutes seconds
(only if run completed)

Resting Pulse: 15 second count

Recovery Pulse: 1 minute count

Sit & Reach:

	0.5	1.0	1.5	2.0	2.5	3.0	3.5	4.0	4.5	5.0	5.5	6.0
Before toes	<input type="checkbox"/>											
Touch toes	<input type="checkbox"/>											
After toes	<input type="checkbox"/>											
	0.5	1.0	1.5	2.0	2.5	3.0	3.5	4.0	4.5	5.0	5.5	6.0

Push-ups: 1 minute

Crunches: 1 minute

Member Signature

Buddy Signature