

Health and Medical History

Name _____ Date _____

Date of birth _____

Street address _____

City/State/Zip _____

Phone (home) _____ (work) _____

Email address _____ (cell phone number) _____

Emergency contact:

Name / Relationship _____ Phone _____

Physical activity should not pose any problem or hazard to the majority of people. The following questions are designed to identify the small number of adults for whom physical activity might be inappropriate or those who should seek medical advice prior to initiating a fitness program or other change in their physical activity levels.

Yes No

- | | | |
|-------|-----|---|
| ___ | ___ | 1. Are you over age 55 and/or not accustomed to vigorous exercise? |
| ___ | ___ | 2. Have you ever been diagnosed with Type I or Type II Diabetes? |
| ___ | ___ | 3. Do you have any reason to suspect that you might now pregnant, or have you been pregnant within the last 3 months? |
| ___ | ___ | 4. Have you had any major or minor surgery in the past 3 months? |
| ___ | ___ | 5. Have you been hospitalized in the last 2 years? If so, when and for what reason? |
| _____ | | |
| ___ | ___ | 6. Are you currently, or have you in the past, ever seen a chiropractor or physical therapist for any condition? If yes, when and for what condition? |
| _____ | | |
| ___ | ___ | 7. Do you ever experience unexpected shortness of breath, or labored breathing, with or without pain? If yes, describe under what conditions. |
| _____ | | |
| ___ | ___ | 8. Do you currently, or have you ever, experienced unexplained heart palpitations or been diagnosed with a heart murmur or irregular heartbeat? |

Yes No

___ ___ 9. Have you ever been diagnosed with high blood pressure? If yes, when? _____

___ ___ 10. Do you know what your blood pressure normally is? If yes, please state _____ / _____

___ ___ 11. Do you currently smoke? If yes, how many cigarettes per day? _____

___ ___ 12. Did you ever smoke? If yes, how long ago did you quit?

___ ___ 13. Is there any history of heart disease (prior to age 55) in your immediate family? If yes, explain.

___ ___ 14. Do you know your cholesterol levels? If so, please state: _____

___ ___ 15. Do you receive regular annual physical exams from your primary care physician? Date of last exam:

___ ___ 16. Do you have any pain, discomfort, or known current or previous injury to any of the following areas:

___ ___ Right or left knee (circle as appropriate)

___ ___ Right or left shoulder (circle as appropriate)

___ ___ Right or left elbow (circle as appropriate)

___ ___ Right or left elbow (circle as appropriate)

___ ___ Right or left wrist (circle as appropriate)

___ ___ Right or left ankle (circle as appropriate)

___ ___ Right or left hip (circle as appropriate)

