WELLNESS INFORMATION FORM

Full Name: _____

Day Phone: _____ Height _____

Weight _____Gender: _____ Age: _____

Date of Birth: _____

In case of emergency (please contact)

Name:

_____

Phone:

_____

Relationship:

_____

Confidential Medical History

1. Date of Most Recent Medical Examination:

   _____

2. Do you feel fine – Without Restrictions?
   Yes _____ No _____
   If no, Please Describe:

   _____

   _____

3. Do you have a heart condition?
   Yes _____ No _____
   If yes, please describe:

   _____

   _____

4. Have you ever been hospitalized or treated for a physical injury?
   Yes _____ No _____
   If yes, please describe:

   _____

   _____

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5. Have you ever been injured and not received medical attention?
   Yes _____ No _____
   If yes, please describe:
   _____
   _____

6. Do you have any medical conditions for which you are currently being treated?
   Yes _____ No _____
   If yes, please describe: _____
   _____

7. Are you currently using any prescription medications? Yes _____ No_____
   If yes, please describe: _____
   _____
   _____

8. Do you have:

   Any known Allergies?
   Yes ____ No ____

   Difficulty Breathing?
   Yes ____ No ____

   High Blood Pressure?
   Yes ____ No ____

   Diabetes?
   Yes ____ No ____

9. Do you ever lose your balance because of muscle fatigue? Yes _____ No _____
   If yes, please describe:
   _____
   _____

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10. Have you been diagnosed with Osteoporosis? Yes _____ No _____
If yes, what stage: _____

11. Do you lose your balance because of dizziness or do you ever lose consciousness?
Yes _____ No _____
If yes, please describe:
_____
_____

12. Do you have a bone or joint condition that could be made worse by repetitive motion?
Yes _____ No _____
If yes, please describe:
_____
_____

13. Do you know any other reason why you should not participate in this program?
Yes _____ No _____
If yes, please describe:
_____
_____

_____ _____
Initials

The above information is complete, true and accurate to the best of my knowledge.

_____
Signature

_____
Instructor Check

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