Initial Consultation-Fitness Participant

Name_____ Date_____

DOB_____ Age_____

Street Address_____City_____Zip_____

Home phone_____Work Phone_____

Email_____

Emergency Contact_____Daytime/Cell Phone_____

Occupation_____

Work activity level: Sedentary Mildly Active Active Very Active
Work-related stress: Low Moderate High
Regular Hours: Yes No

The health record is a critical element in the determination of a client's risk of injury in program participation. Please take time to read and answer all questions before seeing a physician for a physical examination.

Have you suffered from or been diagnosed with any of the following: (Circle)

High blood pressure	Breathing difficulties
Pulmonary disease	Vascular disease
Cancer	Recent illness
Seizures	Diabetes
Allergies	Tremors
Hernia	Back/neck pain
Joint condition/injury	Soft tissue injury
Ankle edema	Unusual fatigue
High cholesterol	High HDL cholesterol

1. Has anyone in your family (grandparents, mother, father, brother, sister, aunt, uncle) died suddenly before age 50?	YES	NO	Don't Know
2. Have you ever stopped exercising because of dizziness or passed out during exercise?	YES	NO	Don't Know
3. Do you have asthma (wheezing), hay fever, or coughing spells after exercise?	YES	NO	Don't Know
4. Have you ever had a broken bone, had to wear a cast, or had an injury to any joint?	YES	NO	Don't Know
5. Do you have a history of concussion?	YES	NO	Don't Know
6. Have you ever suffered a heat-related illness (heat stroke)	YES	NO	Don't Know
7. Do you have a chronic illness or see a doctor regularly for any particular problem?	YES	NO	Don't Know
8. Do you take any medication?	YES	NO	Don't Know
9. Are you allergic to any medications or bee stings?	YES	NO	Don't Know
10. Do you have only one of any paired organs? (Eyes, ears, kidneys, testicles, ovaries)	YES	NO	Don't Know
11. Have you had an injury in the last year that caused you to miss 3 or more consecutive days of work?	YES	NO	
12. Have you had surgery or been hospitalized in the past year?	YES	NO	Don't Know
13. Have you missed more than 5 consecutive days of participation in usual activities because of illness, or have you had a medical illness diagnosed that has not been resolved in the past year?	YES	NO	Don't Know
14. Are you worried about any problem or condition at this time?	YES	NO	Don't Know

Please give details on any "YES" answer from the above health history.

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_____

_____

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_____

Please complete reverse side

If my health should change so that I could answer "YES" to any of the above questions, I,_____, am responsible for informing my health/fitness professional.

Signature: _____Date_____

Family Physician _____
Physician's Phone_____

Please complete reverse side