HEALTH ASSESSMENT

NAME:

DOB

Primary Physician's Name & Contact

Do you have any form of Heart Disease?

Have you ever experienced shortness of breath/chest pain?

If Yes, please explain here.

Date of last Physical?

Do you have or do any of the following pertain to your health: If yes, please explain.

High Blood Pressure?

If Yes, provide levels here.

Cigarette Smoking?

Diabetes?

If Yes, Type?

Family History of Heart Disease?

If Yes, Who/Age?

How often do you currently exercise/ week?

- ◯ 0
- ◯ 1-2
- ◯ 2-3
- ◯ 3-4
- ◯ 4-7

What medications are you taking currently and why?

Do you have problems in the following areas?

- [ ] Knees
- [ ] Lower Back
- [ ] Neck/ Shoulders
- [ ] Hips/Pelvis
- [ ] Other

Please explain anything you checked in the prior question.

Is there any reason you know of that you should not participate in exercise?

If there is a reason you should not participate in exercise, please explain here.

Signature:

Date: