Health Screening Form

Name:_____Birthdate:_____

Address: _____

Phone: _____Cell:_____Email:_____

Emergency Contact: _____Phone:_____

Have you ever been treated by a physician for:
___ heart disease
___ diabetes
___ high blood pressure
___ gastric reflux
___ glaucoma
___ vertigo
___ pulmonary disease (emphysema, COPD)
___ orthopedic/joint (shoulder/elbow/spine/hip/knee) problems
___ osteoporosis/osteopenia
___ arthritis
___ peripheral neuropathy (numbness/tingling/diminished sensation)
___ other: _____

Are you pregnant? Yes No Prior delivery dates: _____

Prior surgeries
_____

Prior injuries
_____

Do you carry a list of your current medications? Yes No
Please List: _____

Activity level/exercise frequency
_____
_____