Health and Exercise History

THE STRETCH Lady™

NAME_____ AGE/BIRTHDAY _____

ADDRESS_____

HOME PHONE_____ WORK PHONE _____

EMAIL _____

NAME/NUMBER/RELATIONSHIP OF EMERGENCY CONTACT

_____

OCCUPATION_____

DO YOU USE TOBACCO?_ _____ DO YOU DRINK ALCOHOLIC BEVERAGES?_____

PRIOR EXERCISE HISTORY INCLUDES_____

_____

HAVE YOU EXPERIENCED ANY OF THE FOLLOWING IN THE PAST OR PRESENT?

- ☐ SHORTNESS OF BREATH
- ☐ HEART DISEASE/ PACEMAKER
- ☐ SHOULDER PROBLEMS OR PAIN
- ☐ CANCER
- ☐ DIABETES
- ☐ HYPOGLYCEMIA
- ☐ HIGH BLOOD PRESSURE
- ☐ EATING DISORDER
- ☐ HEADACHES
- ☐ NUMBNESS/TINGLING
- ☐ BACK PROBLEMS OR PAIN
- ☐ KNEE PROBLEMS OR PAIN
- ☐ NECK PROBLEMS OR PAIN
- ☐ INSOMNIA
- ☐ ARTHRITIS
- ☐ SEIZURES
- ☐ THYROID DYSFUNCTION
- ☐ DIZZINESS
- ☐ SEIZURES
- ☐ FRACTURES OR BROKEN BONES

PLEASE EXPLAIN ANY SPECIFIC TREATMENT YOU HAVE RECEIVED FOR THIS PROBLEM, SURGERY, PREVIOUS PHYSICAL THERAPY, CHIROPRACTIC VISITS, PAIN MEDICATIONS, ETC.

_____

_____

WHEN WAS YOUR LAST COMPLETE PHYSICAL? _____

ARE YOU AWARE OF ANYTHING IN YOUR MEDICAL BACKGROUND THAT COULD AFFECT YOUR ABILITY TO EXERCISE?

_____

ARE YOU TAKING ANY MEDICATIONS? _____ IF YES, PLEASE LIST BELOW. INCLUDE VITAMINS & SUPPLEMENTS.

_____

DO YOU HAVE ANY ALLERGIES? YES ☐ NO ☐ IF YES, PLEASE EXPLAIN _____

IF INJURED, WHAT ARE YOUR GOALS FOR RECOVERY? ☐ INCREASE IN MOVEMENT ☐ INCREASE IN STRENGTH

☐ RETURN TO SPORT ☐ RETURN TO WORK ☐ OTHER _____

WHAT TYPE OF MUSIC DO YOU LIKE? _____ DO YOU FEEL THAT YOU KNOW HOW TO RELAX?_____