Health History Form

Class Information
Site name: _____ Class time: _____

Thank you for taking the time to complete this form. While you may leave any question blank, we encourage you to complete the form. It provides essential information about your health and fitness level for your Instructor. **All your answers will be kept strictly confidential.**

Personal Contact Information

Name: _____ Birth Date: ☐☐ / ☐☐ / ☐☐☐☐ (Month / Day / Year)

Address: _____ Gender: ○ Female ○ Male ○ Other

Apt/Unit: _____ Phone 1: (_____) _____ - _____

City: _____ Phone 2: (_____) _____ - _____

State: _____ Zip Code: _____ Email: _____@_____

Emergency Contact Person

Name: _____ Relationship: _____

Phone: (_____) _____ - _____

Physician Information

Name: _____ Phone: (_____) _____ - _____

Address: _____ Suite: _____

City: _____ State: _____ Zip Code: _____

- What do you **hope to accomplish** by participating in this exercise program?

  _____

Health Information

- What **medications** do you currently take? Please include *dosage* and *frequency* for each.
  (Attach additional sheet if necessary.)

  Medication _____ Medication _____

  Dose_____ Frequency _____ times/day Dose_____ Frequency _____ times/day

  Medication _____ Medication _____

  Dose_____ Frequency _____ times/day Dose_____ Frequency _____ times/day

- Do you have any **allergies** to any foods or medications? If so, please list.

  _____

  _____

PART I: HEALTH HISTORY

- Do you have a history of any of the following? (Mark all that apply, including the year the condition was diagnosed or first developed.)

√	Year		√	Year		√	Year	
		Alzheimer's disease			Foot/ankle swelling			Parkinson's disease
		Arthritis			Heart attack			Poor leg circulation
		Back problems			Heart disease			(left right both)
		Blackouts			Heart surgery			Rheumatic disease
		Broken bones			Hernia			Seizures or epilepsy
		Cancer			High blood			Severe headaches
		Chest pain/angina			pressure/Hypertension			Shortness of breath
		Cholesterol over 240			Irregular/rapid heart beats			Smoking
		Congestive heart failure			Knee injuries			(# cigarettes per day____)
		Depression			Lung disease/ breathing			Stroke
		Diabetes			Macular degeneration			Surgery in past year
		Dizziness or blurred vision			Memory loss			Unsteadiness
		Double vision			Multiple sclerosis			Weakness
		Emphysema			Osteoporosis			
		Fall(s)			Pacemaker/defibrulator			

Other conditions or additional information_____

_____

PART II: SELF-ASSESSMENT

Do you believe you are physically fit?	❑ Yes	❑ No
Are you happy with your current weight?	❑ Yes	❑ No
Can you stand up from a chair without using the arms?	❑ Yes	❑ No
Can you get up from the floor without assistance?	❑ Yes	❑ No
Can you stand on one leg without support?	❑ Yes	❑ No
Can you walk up and down steps without using the handrail?	❑ Yes	❑ No
Can you walk around a city block without being short of breath?	❑ Yes	❑ No

- What types of exercise do you currently do on a regular basis? Place a check mark next to each and <u>indicate how many times a week you do it per week on the line next to it</u>.

❑ Aerobics _____	❑ Martial Arts _____	❑ Swimming _____	❑ Weight lifting _____
❑ Biking _____	❑ Rowing _____	❑ Tai-Chi _____	❑ Yoga _____
❑ Dancing _____	❑ Skating _____	❑ Tennis _____	❑ Other: _____
❑ Jogging _____	❑ Stretching _____	❑ Walking _____	_____

I, _____, hereby acknowledge that all the above information is true. I release Senior Services (Seattle, WA) and all of its agents from all liability for any accident, injury or damages of any kind to persons or property that might occur while I participate in an EnhanceFitness® class.

_____ _____

Signature *Date*