Up Athletics & Rehab

Personal Health Screen Form (Up Athletics & Rehab)

Full Name: Birth Date:

Phone Number:

Please answer the following questions:

Do you suffer from any of the following?

1. Heart disease ○ Yes ○ No
2. High Blood Pressure ○ Yes ○ No
3. Diabetes ○ Yes ○ No
4. Asthma ○ Yes ○ No
5. Epilepsy ○ Yes ○ No
6. Hypoglycemia ○ Yes ○ No
7. Arthritis ○ Yes ○ No
8. Often feel faint or have spells of severe dizziness ○ Yes ○ No
9. Have you recently had any surgery? ○ Yes ○ No
   If yes, please explain: (max 200 character)

10. Do you feel pain in your chest at rest, during your daily activities of living, or when you do physical activity? Please answer NO if your dizziness was associated with over-breathing (such as during vigorous exercise). ○ Yes ○ No
If yes, please explain: (max 200 character)

11. Do you lose balance because of dizziness, or have you lost consciousness in the last 12 months? ○ Yes ○ No

Up Athletics & Rehab

12. Have you ever been diagnosed with another chronic medical condition (other than heart disease or high blood pressure)? ◯ Yes ◯ No

If yes, please explain: (max 200 character)

13. Are you currently taking prescribed medications for a chronic medical condition?
Please list condition(s) and medication(s) here: (max 200 character) ◯ Yes ◯ No

14. Do you currently have (or have had within the past 12 months) a bone, joint, or soft tissue (muscle, ligament, or tendon) problem that could be made worse by becoming more physically active? (Please answer NO if you had a problem in the past, but it does not limit your current ability to be physically active). ◯ Yes ◯ No
f yes, please explain: (max 200 character)

15. Do you have a history of back trouble? ◯ Yes ◯ No
If yes, please explain: (max 200 character)

16. Are you currently suffering from, or receiving treatment for any injuries? ◯ Yes ◯ No
If yes, please explain: (max 200 character)

17. Has your doctor ever said that you should only do medically supervised physical activity?
Yes No

18. Do you have any other medical conditions that may be affected by your participation in a fitness test or exercise program?
Yes No

If yes, please explain: (max 200 character)

19. If Female, are you pregnant?
Yes No

If you answered yes to one or more of the questions above, or you know of any other potential risks to your health and well-being by participating in an exercise program, it is your responsibility to consult with your (a) physician to ensure you have been adequately informed on the risks and any restrictions or contraindications for exercise they may present, no more than 30 days prior to starting the fitness program and that you have communicated this information to the kinesiologist at Up Athletics & Rehab.

Legal Waiver:
I am aware of, and appreciate that there are risks of injury or possible death with my participation in any fitness testing or physical exercise program at Up Athletics & Rehab. By signing the form below, I indicate that I have read, understand and will comply with the directions on this form and that I will assume all legal liability and waive any and all rights of recovery with respect to myself, beneficiaries or heirs, should I choose not to consult with a physician or follow their recommendations. The information on this form will be kept confidential.

Participant's Signature: Date:

.