Office Use Only
Trainer_____
Class Type_____

MEDICAL HISTORY AND WAIVER

Client Information:

Last Name_____ First Name_____ Date_____

Address_____ Birth Date_____

City_____State_____Zip_____

HomePhone_____CellPhone_____WorkPhone_____

Age_____ Male ❑ Female ❑ T-Shirt Size (please circle one)

Email_____ S M L XL XXL

If Applicable: School_____ Sports Played_____

Emergency Contact Information:

Name _____ Relationship _____

Preferred Phone _____ Other Phone _____

Physical Activity Readiness Questionnaire	**Yes**	**No**
1. Has a doctor ever said you have a heart condition and recommended only medically supervised physical activity?.....	❑	❑
2. Do you have chest pain brought on by physical activity?.....	❑	❑
3. Do you tend to lose consciousness or fall over as a result of dizziness?.....	❑	❑
4. Has a doctor ever recommended medication for your blood pressure or a heart condition?.....	❑	❑
5. Do you have a bone or joint problem that could be aggravated by the proposed physical activity?.....	❑	❑
6. Are you aware through your own experiences or a doctor's advice of any other physical reason against your exercising without medical supervision?.....	❑	❑

7. Are you over the age of 65 and not accustomed to vigorous exercise?…… ❑ ❑

If you answered Yes to one or more of the questions above, please answer and initial the following questions.

	Yes	No	
8. Have you consulted your physician regarding increasing your physical activity and/or performing a fitness assessment?……	❑	❑	☐
9. If you answered NO to question 8, will you consult your physician prior to increasing your physical activity and/or performing a fitness assessment?……	❑	❑	

Medical History: Please check <u>all</u> conditions that apply (confidential – for internal use only)

	Medications Yes	Medications No
1. ❑ Heart Disease or Stroke	❑	❑
2. ❑ High Blood Pressure	❑	❑
3. ❑ High Triglycerides	❑	❑
4. ❑ Cancer	❑	❑
5. ❑ Lung / Pulmonary Disease	❑	❑
6. ❑ Kidney Disease	❑	❑
7. ❑ Osteoporosis	❑	❑
8. ❑ Ulcer	❑	❑
9. ❑ Gastrointestinal Disease	❑	❑
10. ❑ Diarrhea	❑	❑
11. ❑ Depression	❑	❑
12. ❑ Diabetes Mellitus	❑	❑
13. ❑ Obesity	❑	❑
14. ❑ Arthritis	❑	❑
15. ❑ Anemia	❑	❑
16. ❑ Food Allergies	❑	❑
17. ❑ Neuromuscular Disease	❑	❑
18. ❑ Arteriosclerosis	❑	❑
19. ❑ Gallbladder Disease	❑	❑

	Medications Yes	Medications No
20. ❑ Low back pain within last 6 months	❑	❑
21. ❑ Psychological Problems	❑	❑
22. ❑ Anorexia	❑	❑
23. ❑ Bulimia	❑	❑
24. ❑ Compulsive Overeating Disorder	❑	❑
25. ❑ Pregnant / Lactating / Trying to conceive	❑	❑
26. ❑ Currently being monitored or have been advised to be monitored by a physician	❑	❑
27. ❑ Recommended high level care	❑	❑
28. ❑ Special diet	❑	❑
29. ❑ Other medical condition(s) that may have any impact on your participation in the U-District personal training, sports performance, yoga, or pilates programs (If checked, please explain)	❑	❑

_____

Please list any medications you are currently taking: _____

I, the above enrolled, understand that neither Rock and Armor Physical Therapy and Sports Performance, nor anyone employed by the facility will assume responsibility for accidents and/or other expenses incurred as a result of participation in this program, and regardless of location of the training program (clinic setting, court setting, field setting, etc). I attest that the above is in good health and able to participate in a vigorous athletic program. In the event of injury or illness, the facility has my permission to provide emergency first aid care and seek the appropriate care necessary.

Client's Signature_____ Date _____

If client is under the age of 18, the signature of a parent or guardian is also required.

Parent's Signature _____ Date _____