Health History

Check any of the following that apply to your health (currently or in the past):

- [ ] Heart Condition - if yes specify
- [ ] High Blood Pressure or on Blood Pressure Medicine
- [ ] Cardiac Surgery – if yes, what kind and when
- [ ] Pain in your chest while doing physical activity
- [ ] Diabetes
- [ ] Respiratory Disease/Illness ______(type)
- [ ] Cancer________________ (type)
- [ ] Parkinson’s Disease
- [ ] Multiple Sclerosis
- [ ] Stroke- when and how affected
- [ ] Arthritis (Type: □ Osteo □ Rheumatoid)
- [ ] Post-Polio Syndrome
- [ ] Muscular Dystrophy
- [ ] Ataxia
- [ ] Chronic Dizziness
- [ ] Morbid Obesity
- [ ] Visual Impairment
- [ ] Autism
- [ ] Spinal Muscular Atrophy
- [ ] Neuropathy
- [ ] Lymphedema or swelling in the extremities
- [ ] Osteogenesis Imperfecta
- [ ] Cerebral Palsy
- [ ] Spina Bifida
- [ ] Epilepsy or Seizure Disorder
  Date of most recent: ___/___/____
- [ ] Brain Injury
- [ ] Shunt
- [ ] Any other chronic medical condition
- [ ] Orthopedic Surgery – type and date
- [ ] Any bone or joint problems that limit you from engaging in physical activity- if yes specify
- [ ] Currently Pregnant
- [ ] Other __________________________
  Amputation- level__________________________
  Prosthesis □ Yes □ No
- [ ] Spinal Cord Injury
  □ Level___________ □Complete □Incomplete
- [ ] Learning or emotional disability
- [ ] Incontinence
- [ ] On a bladder management program
- [ ] On a bowel management program
- [ ] Current pressure sore(s)
- [ ] Current open wound(s)
- [ ] Seizure in past 6 months

Medications (prescription and over the counter)

________________________________________________________________________________
________________________________________________________________________________

Allergies: ________________________________

Will a caregiver or family member be attending with you? □ Yes □ No

Do you use a walker, cane or wheelchair to get around inside the home or in the community? □ Yes □ No

Are you currently receiving Physical therapy or Occupational Therapy? If yes, please explain

________________________________________________________________________________

All new members undergo an initial fitness orientation with one of our Trainers where individual goals and expectations are assessed and discussed. Our staff will develop and assist in the management of a customized exercise plan specifically designed to meet the needs of our members. If it is determined that an individual’s personal fitness goals exceed their ability to operate independently and safely, or if they will require the constant assistance of a Chapter 126 staff member, we would recommend scheduling Personal Training sessions (for an additional fee) in order to ensure the one-on-one time is reserved just for you. ________ (please initial)