Health History Form

Thank you for taking the time to complete this form. Please print your answers to the questions on both sides of 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 to your Instructor.
All your answers will be kept strictly confidential.

Your Name: _____

Your Home Phone: (_____) _____ - _____

Emergency Contact Information:

Name/ relationship: _____/ _____

Phone: (_____) _____ - _____

What medications do you take?_____

_____

Do you have any allergies to food or medications? If yes, please list: _____

_____

What do you wish to accomplish by participating in this exercise program?

_____

_____

Your Doctor's Name: _____

Doctor's Phone: (_____) _____- _____

Clinic Name, Mailing Address: _____

City: _____ State: _____ Zip: _____

Chronic Conditions

Have you ever been told by a doctor or other health professional that you have any of the following conditions? (Mark all that apply.)

- ❑ Arthritis
- ❑ Rheumatic disease
- ❑ Cancer
- ❑ Diabetes
- ❑ Depression
- ❑ Heart disease
- ❑ Hypertension
- ❑ Lung disease/ Breathing problems

OR

- ❑ No chronic conditions

Other Conditions

Do you have history of any of the following? (Mark all that apply. If yes, note year it began.)

- ❑ Alzheimer's Disease
- ❑ Artificial joint (where?_____)
- ❑ Back problems
- ❑ Blackouts
- ❑ Broken bones
- ❑ Chest pain/ angina
- ❑ Cholesterol > 240
- ❑ Congestive heart failure
- ❑ Dizziness or blurred vision
- ❑ Double vision
- ❑ Emphysema
- ❑ Fall(s)
- ❑ Foot/ ankle swelling
- ❑ Heart attack
- ❑ Heart surgery
- ❑ Hernia
- ❑ Irreg./rapid heart beats
- ❑ Knee injuries
- ❑ Macular degeneration
- ❑ Memory loss
- ❑ Multiple sclerosis
- ❑ Osteoporosis
- ❑ Pacemaker/ defib.
- ❑ Parkinson's
- ❑ Poor leg circulation (left / right / both?)
- ❑ Seizures or epilepsy
- ❑ Severe headaches
- ❑ Shortness of breath
- ❑ Smoking (#/ day____)
- ❑ Stroke
- ❑ Surgery in past year
- ❑ Unsteadiness
- ❑ Weakness

Other conditions or additional information: _____

_____

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 exercise do you currently do on a regular basis? (Please mark and state number of times per week next to the exercise)

- ❑ Walk
- ❑ Jog
- ❑ Row
- ❑ Yoga
- ❑ Bike
- ❑ Dance
- ❑ Swim
- ❑ Stretch
- ❑ Skate
- ❑ Tai-Chi
- ❑ Tennis
- ❑ Weight Lift
- ❑ Martial Arts
- ❑ Aerobics
- ❑ Other_____
- _____

I, _____, hereby acknowledge that all the above information is true. I release Sound Generations (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:*** _____

Activity Level

Rate on a scale of 0 to 4 the level of help you need in the following areas; 0 being no help:

Function	Need for assistance	Function	Need for assistance
Eating	0 1 2 3 4	Using a telephone	0 1 2 3 4
Bathing	0 1 2 3 4	Light housework	0 1 2 3 4
Dressing	0 1 2 3 4	Heavy Housework	0 1 2 3 4
Using the toilet	0 1 2 3 4	Taking medications	0 1 2 3 4
Getting in/out of bed	0 1 2 3 4	Using transportation	0 1 2 3 4
Walking	0 1 2 3 4		
Preparing meals	0 1 2 3 4		

How many times have you fallen in the last 12 months?_____

Please describe what caused the fall:_____

_____

_____

_____

Thank you so much for your help!