

OFFICE USE ONLY

CLIENT NAME: _____

1. Class/Retreat Registering For: _____ Instructor: _____

2. Payment Received: _____ Cash _____ Check No. (_____) _____ PayPal/Credit Card

Mindful Fitness, LLC • PO Box 1527, Camano Island, WA 98282

Today's Date: _____

Client Health Worksheet

Name: _____ Birthday: _____ Age: _____

Address: _____ Email: _____

Home Phone: _____ Business Phone: _____ Cell Phone: _____

Physician's Name: _____ Phone No.: _____

Name of Spouse: _____ Names & ages of children: _____

Emergency Contact/Name & Relationship: _____ Phone No.: _____

Referred by: _____

1. Please list the last three times you have been hospitalized. (Women do not need to list normal pregnancies):

Reason for Hospitalization

Month and Year

_____	_____
_____	_____
_____	_____

2. Please list any chronic or serious medical conditions/illnesses:

3. Please list any injuries, dislocations, fractures or strains:

4. Do you have any of the following conditions that may limit your physical activity? Please check all that apply (and indicate "L" for left or "R" for right)

- | | | | |
|-------------------------------|-------------------------|--------------------------------|--------------------|
| _____ Ankle/foot injury | _____ Bone fracture | _____ Shoulder/clavicle injury | _____ Arthritis |
| _____ Low back pain | _____ Wrist/hand injury | _____ Arm/elbow injury | _____ Tennis elbow |
| _____ Knee/thigh injury | _____ Hip/pelvic injury | _____ Calcium deposits | _____ Dizziness |
| _____ Nerve damage | _____ Upper back injury | _____ Head/neck injury | _____ Fainting |
| _____ Swelling in feet/ankles | _____ Other | | |

If **other**, please explain:

Have you experienced . . .

- | | | |
|---|-----------|----------|
| Unusual pain or discomfort in your chest? | _____ yes | _____ no |
| Unusual shortness of breath during moderate exercise? | _____ yes | _____ no |
| Unusual heartbeats, such as skipped beats or palpitations? | _____ yes | _____ no |
| Do you get cramps or pains in your legs or feet? | _____ yes | _____ no |
| Do you experience sudden tingling, numbness or loss of feeling in your arms, hands, legs, feet or face? | _____ yes | _____ no |

5. Please list any medications you are currently taking:

6. Has your physician ever advised you against exercise? _____ yes _____ no

7. Are you presently receiving physical therapy? _____ yes _____ no

If yes, why?