Training Camps

Health History Questionnaire

Answer Each Question By Printing The Necessary Information. Your Answers Are Confidential.

Name:	Date of Birth:	Age:
Address:		
City, State, Zip:		
Home Phone:	Work Phone:	
Employer:	Occupation:	
In case of emergency, please notify:		
Name:	Relationship:	
Address:		
City, State, Zip		
Home Phone:	Work Phone:	

Medical Information

Physician:	Phone:	
Are you under the care of a physician, chiropractor, or other health care professional for any reason? If yes, list reason:	❒ Yes	❒ No
Are you taking any medications? *(If yes, complete the following)* Type: Dosage/Frequency: Reason for Taking:	❒ Yes	❒ No
Please list any allergies:		
Has your doctor ever said your blood pressure was too high?	❒ Yes	❒ No
Has your doctor ever told you that you have a bone or joint problem that has been or could be made worse by exercise?	❒ Yes	❒ No
Are you over the age of 65?	❒ Yes	❒ No
Are you unaccustomed to vigorous exercise?	❒ Yes	❒ No