FOR YOUTH DEVELOPMENT
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

Information & Health History Form

Name _____ Date_____

Address _____

City/State/Zip Code _____

Home Phone_____ Cell Phone _____

Email Address _____

(Please Print Clearly)

Employment (Company, Position) _____

Date of birth _____ Age _____ Gender M / F

Emergency Contact Name _____

Phone # _____ Relationship _____

Do you now or have you had in the past...

1. A history of heart problems in your immediate family (mother, father, sibling, grandparent)? If so, how old were they?	**Yes**	**No**
2. Cigarette smoking or other tobacco usage?	**Yes**	**No**
3. Elevated blood pressure or taking blood pressure medication?	**Yes**	**No**
4. High cholesterol, triglycerides, or on lipid lowering medications?	**Yes**	**No**
5. Diabetes of thyroid condition, impaired fasting glucose?	**Yes**	**No**
6. Any chronic illness or condition?	**Yes**	**No**

Date of diagnosis and history of symptoms: _____

_____

Current symptoms or problems you experience: _____

_____

Medications: _____

Current mobility level/Do you need to you any assistive devices to walk? **Yes** **No**

If yes, please list: _____

_____

Do you require any assistance for showering or dressing? **Yes** **No**

Do you notice any intolerance to heat or humidity? **Yes** **No**

If yes, how does it affect you? _____

_____

Do you experience bladder or bowel incontinence? **Yes** **No**

Do you have any complaints of pain? **Yes** **No**

If yes, please describe location, sensation and intensity 0-10 (burning, stabbing, aching):

_____

_____

7. Difficulty or fatigue with physical exercise? **Yes** **No**

8. Advice from medical professional not to exercise or modify your exercise? **Yes** **No**

If yes, please explain: _____

_____

9. Recent surgery (within the last 12 months)? **Yes** **No**

If yes, please explain: _____

_____

10. Pregnancy (now or within the last 3 months)? **Yes** **No**

11. History of allergy, breathing, or lung problems? **Yes** **No**

12. Muscle, joint, or back disorder, or any previous injury still affecting you? **Yes** **No**

If yes, please explain: _____

_____

13. A heart condition or heart or vascular disease? **Yes** **No**

14. Do you have pain, discomfort, or other angina equivalent in the chest, neck, jaw, arms, or other areas that might be caused by a lack of blood flow? **Yes** **No**

15. Shortness of breath at rest of with mild exertion? **Yes** **No**

16. Dizziness or fainting? **Yes** **No**

17. Troubled or rapid breathing at night or the need to sit up to breath? **Yes** **No**

18. Ankle or leg swelling? **Yes** **No**

19. Rapid heartbeat or palpitations? **Yes** **No**

20. Calf or leg stiffness or cramping? **Yes** **No**

21. A known heart murmur? **Yes** **No**

22. Unusual fatigue or shortness or breath with normal daily activities? **Yes** **No**

23. Other concerns your fitness professional should be aware of? **Yes** **No**

If yes, please list: _____

What is your current level of activity (work and leisure pursuits)? _____

_____

Are you currently participating in a regular exercise program? **Yes** **No**

If yes, please describe: _____

Are you taking any medication, drugs, vitamins, herbs, or other supplements? **Yes** **No**

If yes, please list type, dose, and reason: _____

_____

Current Weight _____ What do you feel is your ideal weight? _____

Are you seeing a specialists or therapist? **Yes** **No**

Specialists or therapist's name _____

Phone _____

Office Location _____

Physician's Name _____

Phone _____

Office Location_____

Does your physician or specialist know you are participating in this program? **Yes** **No**

What are your personal fitness goals? What do you hope to accomplish through your exercise program? _____

_____

_____

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Physician's Consent Form

I, _____, give permission to

_____ to release my medical records and

medication information to the **Randolph YMCA** for developing my training program.

Signed _____ Date _____

Facility Name **RANDOLPH YMCA** Date _____

Type of Medication _____

_____

Effects:

The person named is planning to enroll in an aquatic exercise class: _____. Movements and skills will be determined by his/her abilities and condition. To make appropriate plans for this individual and to provide a safe environment, we need the following information. Please identify any recommendations, limitations, or restrictions that are appropriate for your patient in this exercise program.

Medication/Physical Conditions:

Blood Pressure: ☐ Normal ☐ High ☐ Low

Cardiac ☐ None ☐ Angina ☐ Congestive Heart Failure

☐ Pacemaker or other cardiac surgery

Diabetes: ☐ None ☐ Insulin Dependent ☐ Diet Controlled

Respiratory Disorders: ☐ None ☐ Restrictive ☐ Obstructive ☐ Asthma

Renal Dysfunction: ☐ Yes ☐ No

Seizure Disorder: ☐ None ☐ Clonic/Tonic ☐ Focal ☐ Unilateral ☐ Bilateral

Does this person need 1:1 attention in the pool? ☐ Yes ☐ No

Other conditions: ☐ None ☐ Orthopedic ☐ Muscle Contractures

☐ Fatigue ☐ Swallowing ☐ Visual Impairments

☐ Cognitive Impairments Other: _____

Continence:

Bladder: ☐ None ☐ Intermittent Catheterization ☐ Indwelling
☐ Suprapubic ☐ Diaper

Bowel: ☐ Constipation ☐ Diarrhea ☐ Bowel Program

Physical Abilities	No Movement	Weak	Fair	Strong
Head/Neck				
Right Arm				
Left Arm				
Trunk				
Right Leg				
Left Leg				

Contraindicated Movement/Activities: _____

Thank You.

Fitness Professional _____

Facility Name **RANDOLPH YMCA**

Phone Number **9733661120** Fax Number **9733668025**

Email **kathy@randolphymca.org**

_____ has my approval to begin an exercise
(Name of Client)
program with the recommendations or restrictions I have indicated above.

Signed _____

Date _____ Phone _____