MCDONALD PHYSICAL THERAPY AND SPORTS REHAB CENTER
WORKOUT PROGRAM-HEALTH AND HISTORY QUESTIONAIRE

Name: _____

Date of Birth: _____ Height: _____ Weight: _____

Mark "X" if the following applies:

Heart Attack:	_____	High Cholesterol:	_____	Irregular Heart Beats:	_____
Operations:	_____	High Triglycerides:	_____	Muscular pain/injury:	_____
Diabetes:	_____	Heart Condition:	_____	Lung/Breathing problems:	_____
Epilepsy:	_____	Back Pain/Injury:	_____	Bone/Joint Pain/Injury:	_____
High Blood Pressure	_____	Chest tightness Pressure:	_____	Other:	_____

Describe all "yes" answers above: _____

_____

List any medications currently taking: _____

Physician Name: _____ **Location of Office:** _____
Last office Visit: _____ **Was Exercise Discussed: Yes _____ No_____**
Have you exercised regularly? Yes _____ No_____ **Do you exercise now? Yes _____ No_____**
What Type of Exercises: _____

_____

Have you ever smoked? Yes _____ No_____ If yes, when did you quit? _____
What are some personal fitness goals: _____
_____

WAIVER

The information stated on this questionnaire is complete and accurate to the best of my knowledge. I realize that there is a risk of injury or harm from exercise which can include, but is not limited to: muscular-skeletal injury, abnormal physiological response (such as blood pressure) and even the possibility of heart attack or stroke. I accept the responsibility for myself to apply any general or specific information regarding exercise and my physical status and realize that McDonald Physical Therapy and Sports Rehab Center, encourages professional evaluation by my physical therapist to significantly lessen my risk for harm. I agree to stop any exercise should it produce pain in any form and notify a staff member immediately. To the best of my knowledge, I am in good health and capable of physical exercise on a regular basis. I hereby release and hold McDonald Physical Therapy and others associated with the clinic harmless for any accident, injury or illness that I may incur as a member. I understand that no guarantee of weight loss or gain of physical change is made or implied. All questions regarding this form have been answered to my satisfaction. I also agree that should I be abusive of any privileges provided by McDonald Physical Therapy, such privileges can be withdrawn at any time.

Signature: _____ **Date:** _____