CRAZY FIT MAMA

Health Questionnaire

Name: ______________________________________ Date: _________________

Address: ___________________________________ Age: _____ DOB: ______

City: _____________________________ State: ____ Sex: __ Weight: ______

Zip: ________________________ E-mail: _______________________________

Home #: _____________ Business #: _____________ Cell #: ____________

Emergency contact: _________________ Phone #: ____________________

Physician name: ____________________ Phone #: _____________________

Address: ____

Date and reason last consulted: _____________________________________

- Has your physician ever advised you against exercising? Yes □ No □
- If yes, please explain:

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  ____

- Are you presently under a physician's care for any other condition? Yes □ No □
- If yes, please explain.

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- Have you had any major illnesses and/or surgeries? Yes □ No □
- If yes, please explain.

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- Do you have any current medical problems or incompletely healed injuries? Yes □ No □
- If yes, please explain.

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- Have you had or do you now have any bone, joint (including spine), or muscle injuries or diseases? Yes ◻ No ◻
- If yes, please explain.
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  ____
- Are you presently receiving physical therapy? Yes ◻ No ◻
- If yes, please explain.
  ____
  ____
- Is there any position, activity, exercise, or task that causes you concern or pain? Yes ◻ No ◻
- If yes, please explain.
  ____
  ____
- In what way do your symptoms interfere with your daily activities? ____
  ____
- If you do experience any pain or discomfort, what causes the symptoms? ____
  ____
- Are you presently taking medications? Please list dosage and reason. ____
  ____

Providing your signature will indicate that all of the information provided above is true to the best of your knowledge. That Crazy Fit Mama will be notified if and when there are any physical or mental conditions that may affect physical activity.

Name: _________________________

Sign: __________________________

Date: __________________________