called out

Health-History Questionnaire

Name _____Date _____

Age _____ Sex ____male ____female

Physician's Name _____

Physician's Phone (_____) _____

Are you taking any medications, supplements, or drugs? _____

If so, please list medication, dose, and reason _____

_____

_____

Please list any medication side effects you experience._____

_____

Describe any physical activity you do somewhat regularly. _____

Describe your swimming ability. _____

Do you have a disability, mobility impairment, or sensory impairment? _____

If yes, please describe. _____

_____

_____

_____

_____

Do you now have, or have you had in the past:	Yes	No
1. Any chronic illness or condition	___	___
2. Difficulty with physical exercise	___	___
3. Advice from physician not to exercise	___	___
4. Recent surgery (last 12 months)	___	___
5. Pregnancy (now or within last 3 months)	___	___
6. History of breathing or lung problems	___	___
7. Muscle, joint, or back disorder, or any injury still affecting you	___	___
8. Renal Disease	___	___
9. Diabetes or metabolic syndrome	___	___
10. Hernia, or any condition that may be aggravated by activity	___	___
11. Seizures	___	___

- IMPORTANT NOTE: If you answered yes to any questions 1-11, please provide a physician written letter of medical clearance for exercise.

12. Thyroid condition	___	___
13. Cigarette smoking (current or past 6 months)	___	___
14. Obesity (body mass index (BMI) greater or equal to 30	___	___
15. Elevated blood cholesterol	___	___
16. History of heart problems in immediate family	___	___
17. Allergic to insect bites or stings	___	___
18. If yes, do you carry medication with you	___	___

So that we can better understand your needs, please list any medical, physical, psychological, or emotional issues not listed above. _____

_____

_____

_____

Signature _____ Date_____

Emergency Contact Name _____

Phone Number _____

Dear Doctor _____:

Your patient, _____, wishes to start a

personalized training program. The activity involves the following: (circle all that apply)

Walking	Running	Biking
Kayaking	Flexibility Training	
Circuit Training	Body Weight Exercises	

If your patient is taking medications that will affect his or her exercise capacity or heart-rate response to exercise, please indicate any recommendations or restrictions the manner of the effect (raises, lowers):

Type of medication/s and effects _____

_____

_____

_____

Please identify any recommendations or restrictions that are appropriate for your patient in this exercise program: _____

_____

_____

Thank you.

Sincerely,

Maralee Teshima

Called Out, LLC

calledoutfitness@gmail.com

_____

_____ has my approval to begin an exercise program with

the recommendations or restrictions stated above.

Signed _____ Date _____ Phone #_____