Brookville FITNESS

Participant Health Information

Name:_____ M / F Date:_____

Address:_____Postal code:_____

Occupation:_____ Email: _____

Age: Phone: cell:

Do you suffer from any of these Medical Conditions:

Spinal injury	_____	Repetitive Strain Injury	_____		
Shoulder injury	_____	Hypoglycemia	____	**RISK FACTORS:**	
Parkinson's Disease	_____	Sciatica	____	Smoking	_____
Fibromyalgia/chronic pain	_____	Asthma/respiratory	____	High or low BP	_____
Osteopenia	_____	Headaches	____	Inactive	_____
Osteoporosis	_____	Back Pain	____	Overweight	_____
Osteoarthritis	_____	Glaucoma	____	Depression	_____
Knee Replacement or Injury	_____	Cancer	____	Stress/anxiety	_____
Hip Replacement	_____	Hernia	____	Allergies to latex	_____
Carpal Tunnel Syndrome	_____	Epilepsy	____	AIDS/HIV	
_____					

Post Cardiac Conditions:		Stroke Date	_____
Heart Surgery Date	_____	Angioplasty Date	_____
Angina	_____	Defibrillator	_____
Diabetes Type	_____	Pacemaker	_____
Myocardial Infraction	_____	Vascular Disease	_____

Describe in Detail on the back of this form, if yes to any of the below:

1. Has a physician given you any Limitations or Restrictions to exercise? _____
2. Do you receive care from a chiropractor or physiotherapist? _____
3. Recent surgery? _____
4. Pregnancy? _____
5. Addiction to drugs or alcohol? _____
6. Prescribed medications or over the counter drugs? _____

I agree that the above information is correct and is to the best of my knowledge.

Signature: _____ Date: _____

emergency contact person: phone number: