MEDICAL HISTORY

This information will be treated confidentially.

Name (print) _____Date_____

Please CIRCLE YES to any of the following conditions you currently have or have had in the past. **CIRCLE NO if it does not apply.**

Heart attack, heart disease, cardiac surgery (yes / no)
Asthma or other respiratory ailments (yes / no)
Migraines or recurrent headaches (yes / no)
Neurological or muscular disorders e.g. Multiple Sclerosis (yes / no)
Arthritis (yes / no), Rheumatoid (yes / no), Osteo (yes / no), Other_____
Light-headedness or fainting (yes / no)
Swollen, stiff or painful joints (yes / no)

High blood pressure (yes / no)	Low blood pressure (yes / no)
Stroke (yes / no)	Bursitis (yes / no)
Diabetes (yes / no)	Kidney Disease (yes / no)
Hernia (yes / no)	Osteoporosis (yes / no)
Epilepsy or seizure (yes / no)	Anemia (yes / no)
Accidents (yes / no)	Fractures / Dislocations (yes / no)

If you marked YES to any of the above, please write the details in the space provided or on the back of this sheet. Include details of any medications you are taking and if there are any side effects as these could influence your performance in class or the type of class you should receive._____

_____

Do you have any conditions, illness, disease or any other medical condition not outlined above, as this may affect either your performance in class or the type of class you should receive. Yes No If YES, please specify:_____

_____

Are you pregnant now, or have you been in the last 3 months? Yes No

Have you had surgery or been hospitalized in the past two years? Yes No

Do you have any injury or problem area e.g. neck, shoulders, low back. Give details including current treatment._____

_____