

CROSSFIT

POWER PERFORMANCE

Power Performance, LLC Health History

Personal Information

Name: _____ Date: _____

Address: _____ City: _____

St: _____ Zip: _____ E-Mail: _____

Phone: H _____ W: _____ C: _____

Place of Employment: _____ Occupation: _____

Date of Birth: _____ Age: _____ M/F

Marital Status (circle): Single Married Divorced

Referred By: _____

Medical Information

Name of Physician: _____ Phone: _____

Date of last full physical: _____ Blood Type: _____

Are you taking any medications? Yes No

If yes, please list medications: _____

Have you or a family member had any form of heart disease? Yes No

If yes, what relation: _____

Have you had an abnormal EKG? Yes No

Controlled by medicine? Yes No Rx Name _____

Do you have asthma? Yes No

Controlled by medicine? Yes No Rx Name _____

Have you ever experienced shortness of breath or chest pains? Yes No

Do you have high or low blood pressure? Yes No (circle which type, if yes)

Do you have high cholesterol? Yes No

Do you currently smoke? Yes No How many per day _____

Have you ever:

Had surgery? Yes No Describe: _____

Been in an accident? Yes No Describe: _____

Broken any bones? Yes No Describe: _____

Do you have problems with any of the following? If yes, please explain.

Knee Yes No Shoulder Yes No

Low Back Yes No Hip/Pelvis Yes No

Neck Yes No Flexibility Yes No

Any Other? _____

Are you under a physician's care for any of the above concerns?

