



MEDICAL HISTORY SURVEY

WELCOME TO OUR STUDIO/CLINIC

ALL CLIENT INFORMATION PROVIDED BY YOU TO KRISTINE MARIE, LLC IS CONSIDERED PRIVATE AND CONFIDENTIAL.

Name: _____ Age: _____ Date: _____

Please check below if you currently have or have ever had any of the following:

- | | |
|--|--|
| <input type="checkbox"/> Elevated blood pressure | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Coronary artery disease | <input type="checkbox"/> Rheumatism |
| <input type="checkbox"/> Heart attack | <input type="checkbox"/> Current/recent pregnancy |
| <input type="checkbox"/> Blood clot | <input type="checkbox"/> Osteoarthritis |
| <input type="checkbox"/> Thrombophlebitis | <input type="checkbox"/> Low back/neck pain |
| <input type="checkbox"/> Congestive heart failure | <input type="checkbox"/> Joint dysfunction |
| <input type="checkbox"/> Peripheral vascular disease (PVD) | <input type="checkbox"/> Bone dysfunction |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Muscle dysfunction |
| <input type="checkbox"/> Any other heart problem that would make exercise unsafe | <input type="checkbox"/> Any physical disability that could interfere with safe exercise participation |
| <input type="checkbox"/> Respiratory dysfunction | <input type="checkbox"/> Latex sensitivity |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Smoking |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Hearing problems |
| <input type="checkbox"/> Unusual shortness of breath | <input type="checkbox"/> Other |
| <input type="checkbox"/> Epilepsy or seizures | |

Please explain any checked items: _____

List previous surgeries: _____

List all medications you are currently taking:

- | | |
|---|---|
| <input type="checkbox"/> Pain Medications | <input type="checkbox"/> Anti-inflammatory |
| <input type="checkbox"/> Muscle relaxants | <input type="checkbox"/> Hypertension/cardiac |
| <input type="checkbox"/> Other: _____ | |

List any allergies: _____

What is your learning preference?

- Handouts Discussion Demonstration Participation

Please provide us with any other information that you feel is relevant to obtaining the best service/care:

PHYSICAL ACTIVITY READINESS QUESTIONNAIRE (PAR-Q)

YES	NO	
		Has your doctor ever said that you have a heart condition and that you should only do physical activity recommended by a doctor?
		Do you feel pain in your chest when you do physical activity?
		Do you lose your balance because of dizziness or do you ever lose consciousness?
		Do you have a bone or joint problem that could be made worse by a change in your physical activity?
		Is your doctor currently prescribing drugs (for example, water pills) for your blood pressure or heart condition?
		Do you know of any other reason why you should not do physical activity?

Note:

1. If you have temporary illness, such as fever or cold, or are not feeling well at this time, you may wish to postpone the proposed activity.
2. If you are pregnant, you are advised to meet with your physician before exercising.
3. If your health changes so that you then answer YES to any of the above questions, tell your fitness or health professional. Ask whether you should change your physical activity plan.

I hereby certify that all information is true to the best of my knowledge. I have read, understood, and completed this questionnaire.

I consent to receive care @ Kristine Marie, LLC.

Signature: _____ Date: _____
(If minor, legal guardian must sign)