FULL OF LIFE FITNESS

Health Questionnaire for Participation in FULL OF LIFE FITNESS

Name_____Date_____

Date of Birth_____Height _____Weight _____

1. Have you been diagnosed with having any of the following conditions?

(Y/N)	*Condition*	*Approximate date of onset*	*Comments*
_____	Cardiac/ HTN	_____	_____
_____	Pacemaker	_____	_____
_____	TIA/Stroke	_____	_____
_____	Angina (chest pain)	_____	_____
_____	Diabetes	_____	_____
_____	Osteoporosis	_____	_____
_____	Osteoarthritis	_____	_____
_____	Rheumatoid Arthritis	_____	_____
_____	Respiratory Disease	_____	_____
_____	Multiple Sclerosis	_____	_____
_____	Parkinson's Disease	_____	_____
_____	Joint Replacement	_____	_____
_____	Cancer	_____	_____
_____	Alzheimer's/Dementia	_____	_____
_____	Balance Disturbance	_____	_____
_____	Spine: Neck/Back.	_____	_____
_____	Other	_____	_____

2. Do you use an assistive device for walking? No ☐ Yes ☐

3. How many times have you fallen in the past year? _____ Hospitalized?_____

4. Do you participate in regular physical exercise such as walking, sports, classes, biking, running or weight training? No ☐ Yes ☐

Type of exercise_____ Frequency_____

5. Please indicate your ability to do each of the following.

	Can do	*with difficulty*	*cannot do*
a. Take care of personal needs such as dressing	☐	☐	☐
b. Bath yourself using tub or shower	☐	☐	☐
c. Climb up and down a flight of stairs	☐	☐	☐
d. Walk outside one or two blocks	☐	☐	☐
e. Do light housework	☐	☐	☐
f. Do shopping for groceries or clothes	☐	☐	☐
g. Walk ½ mile	☐	☐	☐
h. Walk one mile	☐	☐	☐
I. Get down to the floor and up off the floor	☐	☐	☐

I hereby acknowledge that the above information is correct to the best of my knowledge.

SIGNATURE DATE:

I Accept ☐

By checking the "I Accept" box, you are signing this Agreement electronically. You agree your electronic signature is the legal equivalent of your manual signature on this Agreement. By selecting "I Accept" you consent to be legally bound by this Agreement's terms and conditions.