San Diego State University Research Foundation on behalf of
SDSU Fitness Clinic for Individuals with Disabilities

Participant's Health, Medical, and Activity History

Name:_____

Address:_____

City:_____ **State:**_____ **Zip:**_____

Phone #: (_____)_____ **Alternate #:** (_____)_____

E-mail:_____

Date of Birth:_____/_____/_____ **Age:**_____**Gender:**_____

Emergency Contact:_____

Relationship:_____**Phone #:** (_____)_____

How Did You Hear About Us?_____

Diagnosis: _____

_____

_____

_____

Onset:_____

Risk Factors:_____

_____

*What are your fitness goals?*_____

_____

_____

*Are you currently participating in a home exercise program? If yes, describe your program including frequency and duration.*_____

_____

_____

Do you have a personal concern about falls? _____

_____

*If you fall, how often do you fall?*_____

*What are your hobbies?*_____

_____

*What is your current or former occupation?*_____

_____

In general, how would you rate your quality of life? (Circle the appropriate response)

very low low moderate high very high

In a typical week, how often do you leave your house to run errands, go to work, attend meetings, classes, church, social functions, etc.?

- o *less than once a week*
- o *1-2 times per week*
- o *3-4 times per week*
- o *most every day*

Associated Medical Information:

Have you ever been Diagnosed with any of the following? (Check where applicable and include year of diagnosis and treatment)

	Yes	***No***	***Year of Diagnosis and Treatment***
Cardiac disorder	____	____	_____
Angina/Chest pain	____	____	_____
Irregular HR/Murmur	____	____	_____
Hypertension	____	____	_____
Stroke	____	____	_____
Transient Ischemic Attack (TIA's)			
	____	____	_____
High cholesterol	____	____	_____
Peripheral Vascular Disease			
	____	____	_____
Diabetes	____	____	_____
Neuropathies (problems with sensations)			
	____	____	_____
Edema	____	____	_____
Asthma	____	____	_____

	Yes	No	Year of Diagnosis and Treatment
Pulmonary disorders	____	____	_____
Osteoporosis	____	____	_____
Epilepsy or Seizure Disorder			
	____	____	_____
Hernia	____	____	_____
Vertigo/dizziness	____	____	_____
Arthritis	____	____	_____
Speech disorders	____	____	_____
Corrective lenses	____	____	_____
Hearing loss/aids	____	____	_____
Bleeding disorders or are you on a blood thinner?			
	____	____	_____
Depression	____	____	_____
Any other psychiatric disorders:			
	____	____	_____

Do you have a chemical dependency (alcohol &/or drugs)?

	Yes	No	Explanation
	____	____	_____

Are you in any chronic pain?

Yes	*No*	*Explanation*
____	____	_____

Have you had any joint replacement surgeries?

Yes	*No*	*Explanation*
____	____	_____

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*Physician's name:*_____ *Phone :* (_____) _____

*Address:*_____

*City:*_____ *State:* _____ *Zip:*_____

*Are you currently enrolled in Physical Therapy, Occupational Therapy, or another fitness program?*_____

*If yes, what are you working on*_____

_____

_____

*Therapist's name:*_____ *Phone :* (_____) _____

*Address:*_____

*City:*_____ *State:* _____ *Zip:*_____

List all recent hospitalizations and any surgeries:

Date:_____Reason:_____

Date:_____Reason:_____

Date:_____Reason:_____

Date:_____Reason:_____

Date:_____Reason:_____

Date:_____Reason:_____

Date:_____Reason:_____

Medication:

Dosage/Type: ***Purpose*** ***Side Effects:***

_____

_____

_____

_____

_____

_____

Date:_____

Signature:_____