Health Screening Form

Name: _____ Age: _____
Address: _____ Postal Code: _____
Phone: _____ Date: _____

1. Are you currently exercising or physically active? ❑ No ❑ Yes
2. Describe your current exercise program / physical activity

_____

_____

3. Have you been diagnosed with osteoporosis? ❑ No ❑ Yes
4. Have you had a low-trauma fracture? ❑ No ❑ Yes

   If yes, which bone was broken? (e.g., hip, wrist, ribs, spine,etc.) _____

_____

_____

5. Have you had a fall in the last 12 months ❑ No ❑ Yes
6. Has a doctor ever told you not to exercise? ❑ No ❑ Yes

7. Please check those conditions you have now, or have had in the past.
   - ❑ Heart problems including chest pain with activity (angina)
   - ❑ Stroke
   - ❑ High blood pressure
   - ❑ Other chronic illness (please outline below)
   - ❑ Recent surgery
   - ❑ Bronchitis, asthma or emphysema
   - ❑ Significant joint problems
   - ❑ Significant back pain that persisted
   - ❑ Previous injury that is still affecting you
   - ❑ Diabetes
   - ❑ Smoking
   - ❑ High cholesterol
   - ❑ Heart problems in the immediate family
   - ❑ Vision impairment
   - ❑ Hearing impairment

Please put any additional comments here: _____

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