

## FIT FOR PLAY: Registration / Health History

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Phone: (Home) \_\_\_\_\_ (Work) \_\_\_\_\_ (Cell) \_\_\_\_\_

Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M F Social Security #: \_\_\_\_\_

E-mail: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_ Relation: \_\_\_\_\_

Physician: \_\_\_\_\_

List Meds: \_\_\_\_\_

List any sports/hobbies you are interested in? \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

What is your primary reason for taking part in the Fit For Play program? \_\_\_\_\_

**Subjective Wellness Components:** *(please check appropriate box)*

Are you able to understand your limitations, control stress, express emotions appropriately and comfortably, and maintain healthy relationships with others?	NO	YES
Do you have places to live and work that are safe for you both emotionally and physically?	NO	YES
Are you able to learn new skills and also share your knowledge and skills with others?	NO	YES
Do you find your work rewarding, where you can use your special skills and talents to make a positive contribution?	NO	YES
Are you able to manage your physical health on a daily basis?	NO	YES
Are you able to contribute to your community and recognize the interdependence between people and the environment?	NO	YES
Have you ever participated in an exercise program?	NO	YES
Do you have any concerns with starting an exercise program?	NO	YES
Do you receive yearly medical check-ups?	NO	YES
Do you experience any chronic pain? If yes, where?	NO	YES
Do you have any past / current injuries?	NO	YES
Other:	NO	YES

<b>Past Medical History:</b> <i>(please check appropriate box)</i>	<b>Controlled w/ Meds</b>		<b>Comments/Explanations:</b>		
Heart Disease	NO	YES	NO	YES	
High Blood Pressure	NO	YES	NO	YES	
Low Blood Pressure	NO	YES	NO	YES	
Joint Replacement	NO	YES	NO	YES	
Arthritis / Gout	NO	YES	NO	YES	
Back or Neck Trouble	NO	YES	NO	YES	
Hernia	NO	YES	NO	YES	
Asthma / Lung Disease	NO	YES	NO	YES	
Chest Pain	NO	YES	NO	YES	
Diabetes	NO	YES	NO	YES	
Shortness of Breath	NO	YES	NO	YES	

*I have filled out this form honestly to the best of my knowledge. I understand that I am participating in a self-progressed fitness & wellness program & not for the treatment of a specific injury.*

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_