Ball Memorial Hospital

Be Well Program Information and Health History Questionnaire

☐ *Aquatic Class/Open Pool* ☐ *Next Step Plus (Land Exercise)* ☐ *Sports Performance* ☐ *Educational Classes*

Name:_____ **Date:**_____

Date of Birth:_____ Phone:_____

Address:_____

Physician:_____ Physician Phone:_____

* In case of an emergency, we can contact:

	Name	**Relationship**	**Phone**
1.	_____	_____	_____
2.	_____	_____	_____

Please check any conditions listed that pertains to you.

	Heart Attack		Seizures in last 6 months		Neck/Spinal Injuries
	Pacemaker		Total Hip Replacement		Knee Injuries
	Cardiac/Respiratory Problems		High Blood Pressure (140/90)		Ankle/Foot Injuries
	Chest Pain or Discomfort		____ weeks Pregnant		Scoliosis
	Fainting or Unconsciousness		Family History of Heart Disease		Allergies:
	Asthma - *Inhaler? Yes / No Please bring!*		Headaches or Head Injury/Concussion Date: _____		EpiPen Needed? *Please bring!*
	Special Diet:_____		Diabetes Controlled by:_____		Smoker
	Bowel or Bladder Complications		High Cholesterol		Latex allergy
	Hypoglycemia/ low blood sugar		Peanut Allergies		

Medications: ☐ None. ☐ List: _____

_____

Are there any medications that you may have to use during this event? _____ If yes, please list _____

☐ I can administer my own meds ☐ I will need assistance to administer medications.

Recent Hospitalizations? Yes/No. If yes, please list _____

Date of last physical or sports physical:_____ Points of concern?_____

Are you participating in any sports or physical recreational activity? Yes/ No. If yes, please list_____

_____

Please list your goals during participation in Be Well Program:_____

Do you have any other information you would like to bring to our attention: _____

_____

_____ _____

Signature of Participant Date

_____ _____

Signature of Parent or Authorized Representative (if Minor Participant) Date

_____ _____

Witness Date