PUSHING BOUNDARIES

Exercise, health and hope for people with paralysis

Health History Form

All clients must submit a bone density assessment performed within the last year (with the doctor's review & interpretation) if walking is not the primary mode of ambulation for the past 12 months. Please enclose a copy of the report for our files. Pushing Boundaries does not evaluate bone density reports.

Do you have a copy of Bone Density Test with you? Y N	Date of test	Results

Name	Today's date:
Address	
City State Zip	
Email Address	Identify Gender as
Home Phone Cell Phone	Pronouns

	Age	Birthdate	Height	Weight

Emergency Contact	Relationship
Emergency Phone	Email Address
Diagnosis/Type of Injury	Date of Injury/Diagnosis
Level/ Classification	Complete/Incomplete
Rehab	
Treating Hospital	Physician
How would you rate your current health? Excellent Good Fair Poor Unsure	Your health prior to Illness/Injury? Excellent Good Fair Poor Unsure
Who Provides you with Physical Assistance?	
Contact Information:	

Please answer yes or no to the following questions. If Yes, please explain:

Allergies: Y N	Please List:
Breathing Problems: Y N	Please Explain:
Special Needs: Y N Please List:	Have you fallen in the last 6 months? Y N Please Explain:

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Dizziness: Y N Please Explain:	Past Fractures? Y N Please Explain:

Pregnant? Y N Due:	Past Surgeries? Reasons:	Dates:

History of additional Injuries:

Chronic Illnesses or conditions?
Explain:

Have you ever been advised from doctor not to exercise? Y N
Reason:

Has your doctor ever said that you have a heart condition
and that you should only do physical activity recommended by a doctor? Y N

Do you feel pain in your chest when you do physical activity? Y N

In the past month, have you had chest pain when you were not doing physical activity Y N

Is your doctor currently prescribing drugs (i.e. water pills, etc.)
for your blood pressure or heart condition? Y N

Do you smoke? Y N How much per day?	Have you ever smoked? Y N How long ago did you quit?

Date of last physical exam:

Please check any that apply and age of onset:

	You	Mother	Father	Grandparent
High Blood Pressure	☐	☐	☐	☐
High Cholesterol	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐
Bypass Surgery	☐	☐	☐	☐
Stroke	☐	☐	☐	☐
Thyroid Condition	☐	☐	☐	☐
Thyroid Condition	☐	☐	☐	☐

Additional comments:

Education Level:		Veteran?	Y N
Cultural/Religious Beliefs:			
Work Status:		Full Time/Part Time:	

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I have completed the Health & Medical History Questionnaire to the best of my knowledge I have answered all questions completely. In order to make known and diagnosed medical problems or characteristics that may increase the risk of health problems, signs or symptoms indicative of health problems and lifestyle behaviors related to positive or negative health, which I understand that if necessary, Pushing Boundaries reserves the right to request medical clearance which may involve a bone density scan and physician's evaluation and approval before beginning and exercise program, and has the right to deny my participation in the program if requests are not fulfilled.

I also understand that participating in a Pushing Boundaries program while under the influence of any controlled substance (e.g. marijuana) is strictly prohibited and will result in immediate termination of participation in the program if detected.

The information in this application is confidential and protected under the HIPAA Privacy Act.
The information is only to be used by the staff of Pushing Boundaries.

_____	_____	_____
Participant's Signature	Participant's Name (Please Print)	Date

_____	_____
Participant's Guardian (If under 18)	Pushing Boundaries Witness