

# CAMILLE'S BODY SHOP OF NORTHERN MICHIGAN, LLC

## PARTICIPANT HEALTH HISTORY

NAME \_\_\_\_\_ BIRTH DATE \_\_\_\_\_ TODAY'S DATE \_\_\_\_\_

PHYSICIAN'S NAME \_\_\_\_\_ ADDRESS \_\_\_\_\_ PHONE \_\_\_\_\_

EMERGENCY CONTACT \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_ PHONE \_\_\_\_\_

PLEASE LIST ALL MEDICATIONS (INCLUDE HERBALS, VITAMINS & BIRTH CONTROL) \_\_\_\_\_  
\_\_\_\_\_

DOES YOUR PHYSICIAN KNOW YOU ARE PARTICIPATING IN AN EXERCISE PROGRAM? \_\_\_\_\_

HAVE YOU EVER HAD ANY PROBLEMS DURING EXRCISE? \_\_\_\_\_

IF ANY, PLEASE DESCRIBE \_\_\_\_\_

DESCRIBE YOUR PRESENT EXERCISE PROGRAM \_\_\_\_\_

IF YOU ARE NOT ON A PROGRAM NOW, WHEN DID YOU LAST EXERCISE REGULARLY \_\_\_\_\_

ABOUT YOU: ARE YOU MALE \_\_\_ ARE YOU FEMALE \_\_\_

DO YOU HAVE NOW OR HAVE IN PAST:	Yes	No
HEART PROBLEMS OR CHEST PAIN?	_____	_____
HAVE YOU HAD A STROKE OR TIA?	_____	_____
DO YOU HAVE DIABETES?	_____	_____
DO YOU HAVE HIGH BLOOD PRESSURE?	_____	_____
DO YOU HAVE RESPIRATORY PROBLEMS, ASTHMA, OR EMPHYSEMA?	_____	_____
HAVE YOU HAD ANY SURGERY IN THE PAST YEAR?	_____	_____
ARE YOU PREGNANT NOW OR IN THE PAST 3 MONTHS?	_____	_____
DO YOU HAVE MUSCLE, JOINT OR BACK PROBLEMS?	_____	_____
DO YOU HAVE OSTEOPOROSIS?	_____	_____
DO YOU HAVE ARTHRITIS?	_____	_____
IS YOUR CHOLESTEROL ELEVATED?	_____	_____
DO YOU SMOKE?	_____	_____
HAS A PHYSICIAN EVER TOLD YOU NOT TO EXERCISE?	_____	_____
DO YOU NOW OR HAVE YOU EVER HAD A HERNIA?	_____	_____
DOES ANYONE IN YOUR IMMEDIATE FAMILY HAVE HEART DISEASE?	_____	_____
DO YOU HAVE ANY ILLNESS NOT LISTED ABOVE?	_____	_____

PLEASE EXPLAIN ON THE LINES BELOW ANY ANSWERS TO THE ABOVE THAT WERE "YES" \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_