Valetudo Health
Be inspired

HEALTH & MEDICAL QUESTIONNAIRE

The following questionnaire is designed to establish a background of your medical history, and identify any injury and/ or illness that may need to be considered prior to testing and participation in exercise. If you are under 18 then a parent or guardian will need to complete the questionnaire on your behalf or check your answers and then sign in the appropriate section to verify that they are satisfied the answers to all questions are correct to the best of their knowledge.

Please answer all questions as accurately as possible, and if you are unsure about anything please ask for clarification. All information provided is strictly confidential.

If you answer "**yes**" to any non-exercise related question that may affect your ability to complete testing or certain forms of exercise a clearance from a qualified medical practitioner may be required before you can proceed. Please speak with Valetudo Health staff if you are unsure.

Staff at Valetudo Health are not permitted to test or train any minor until a completed medical questionnaire is presented containing a parent or guardian's signature.

If your health conditions/medications change it is important to bring this to the attention of Valetudo Health staff to ensure they can make modifications to your exercise prescription where necessary.

Personal Details

Name: _____

Date of Birth (dd/mm/yyyy): _____ Gender: Female/ Male

Address: _____

Phone (Home): _____ (Work): _____

(Mobile): _____ (E-mail): _____

In case of emergency, whom may we contact?

Name: _____ Relationship: _____

Preferred Phone: _____ Alternate Phone: _____

Personal Medical Practitioner Details

Name: _____ Phone: _____

Fax: _____

Present/Past Medical History

Have you ever had, or do you currently have any of the following? (Tick if yes)

_____ High or abnormal blood pressure

_____ High cholesterol

_____ Rheumatic fever

_____ Heart attack or known heart disease

_____ Known heart murmur

_____ Chest pains

_____ Pain, discomfort in the chest, neck jaw, or arms

_____ Orthopnea (the need to sit up to breathe comfortably)

_____ Paroxysmal nocturnal dyspnea (nigh time unexpected shortness of breath)

_____ Shortness of breath at rest or with mild exertion

_____ Unusual fatigue or shortness of breath with usual activities

_____ Temporary loss of visual acuity or speech, or short-term numbness or weakness in one side, arm, or leg of your body

_____ Fainting or dizziness

_____ Asthma or lung disease

_____ Diabetes

_____ Epilepsy or seizures

_____ Oedema (swelling of ankles)

_____ Cancer

_____ Injury to back (or recurring back pain)

_____ Injury to neck (or recurring neck pain)

_____ Recent operation

____ Severe allergies (please describe)
_____
_____

____ Infectious diseases (please describe)
_____

____ Neurological disorders

____ Neuromuscular disorders

____ Currently taking any medications (if yes, please specify below)
_____
_____
_____
_____
_____

____ Influenza in the last two weeks

____ Recently injured yourself (if yes, please describe below)
_____
_____
_____
_____
_____
_____
_____

____ Recurring muscle or joint injuries (if yes please specify below)
_____
_____
_____

Is there any other condition not previously mentioned which may affect your ability to perform exercise? (if yes, please specify below)
_____
_____
_____
_____

Family History

Have any of your first-degree relatives (parent, sibling, or child) experienced the following conditions? (Tick if yes.) In addition, please identify at what age the condition occurred.

_____ Heart attack

_____ Heart operation (Bypass surgery, Angioplasty, Coronary Stent placement)

_____ Congenital heart disease

_____ High blood pressure

_____ High cholesterol

_____ Diabetes

_____ Other major illness: _____

Are you currently with a private health fund? Yes No

If yes, name of health fund and policy number on the card

_____
_____
_____

If you are consulting us due to an injury please complete the details below:

Have you previously had treatment? Yes No
If yes, please indicate below the place/date/duration

_____
_____

Is your injury associated with either a:

Motor Vehicle Accident (MVA) Yes No

Workers Compensation Yes No

If yes, please complete the details below:

Date of incident: _____
Insurance Company: _____
Claim number:_____
Claims officer: _____
Contact for claims officer: _____

Declaration

I acknowledge that the information provided on this form, is to the best of my knowledge, a true and accurate indication of my current state of health.

Client

Name:_____ Date (dd/mm/yyyy):_____

Signature of client:_____

Signature of Valetudo Health Witness:_____

Parent/ Guardian (if applicable)

I, _____, as parent / guardian of Mr/ Miss _____, acknowledge that I have checked the answers provided to all questions in the medical questionnaire and verify that they are correct to the best of my knowledge.

Signature: _____

Date (dd/mm/yyyy): _____

Medical Practitioner (if applicable)

I, Dr _____, have read the medical questionnaire and information/ consent form provided to my patient Mr/Miss/ Ms_____, and clear him/ her medically for involvement in exercise testing and training.

Date (dd/mm/yyyy):_____

Signature:_____