



WILMINGTON DANCE ACADEMY

Health History

A. Check the appropriate response

- | | | |
|--|-----|----|
| 1. Has your doctor ever told you that you have heart problems | Yes | No |
| 2. Has your doctor ever told you that you have high blood pressure | Yes | No |
| 3. Have you (or a family member) ever had a stroke or heart attack | Yes | No |
| 4. Have you ever had pain in your chest | Yes | No |
| 5. Do you ever feel faint or have dizzy spells | Yes | No |

B. Circle any conditions that you have

- | | | |
|---------------|--------------|---------------------|
| Diabetes | Epilepsy | High Blood Pressure |
| Asthma | Arthritis | High Cholesterol |
| Heart Disease | Osteoporosis | Pregnancy |

C. Have you injured or have pain in the following areas?

- | | | |
|--------|------------|-------------|
| Neck | Upper Back | Shoulders |
| Elbows | Wrists | Lower Back |
| Hips | Knees | Feet/Ankles |

D. Have you had any surgery or broken bones in the last 4 years? Please specify:

E. Are you currently taking any prescribed medications or dietary supplements?

Please specify: _____

F. Are you currently undergoing treatment for any of the following:

- Physical Therapist Chiropractor Massage Therapist

If yes, why?

G. Are there any other reasons (health or personal) that may prevent or limit you from exercising?

H. Are you currently involved in a regular exercise program?

I. What are your goals within this program?

Name: _____

Date: _____

Signature: _____