Medical Screening Form

Client's Name_____ Date of Birth:_____
Phone #:_____ Email address:_____

Emergency Contact Name:_____ Phone #_____

Please tell us the reason for your visit today: (Proactive Preventative/Maintenance, Functional Assessment, Injury Assessment, etc.)

_____

Are you symptoms(circle): *getting worse/ the same/ improving*
How do you sleep at night: *fine/ moderate difficulty/ only with medication*
Do you have problems with: *Hearing/ Vision/ Communication*

Please check all past medical conditions and history that apply to you:

___ High or Low Blood Pressure, ___ Diabetes, ___ Heart Disease
___ Stroke, ___ Osteoporosis, ___ Kidney Disease,___ Rheumatoid Arthritis
___ Osteoarthritis, ___ Seizures, ___ Cancer, ___ Allergies/Asthma

Please explain any checked item: _____
_____
_____

Please circle anything you have experienced in the last 3 months:

Nausea/Vomiting, Fever/Sweats/Chills, Unexplained Weight lose, Numbness/Tingling, Changes in Appetite, Difficulty Swallowing, Shortness of Breath, Digestive Issues, Shortness of Breath, Dizziness, Upper Respiratory Infection, Drastic Change in Health

Please explain any circled item: _____
_____
_____

Are you Currently: __ Under stress, __ Pregnant, __ Depressed

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Please list any surgeries you have had: _____
_____
_____

Liability Waiver

I, the undersigned participant in this private movement and mobility exercise class, as a condition of my participation, hereby waive any and all claims I may have now or in the future against my Instructor and Crossfit Forte (Beach Enterprises LLC), In connection with or arising out of my participation with this individualized mobility class or any injury to myself related hereto.

_____
Print first name, Last Name

_____ _____
Signature Date

_____ _____ _____ _____
Address City State Zip