HEALTH QUESTIONNAIRE

Personal Information

Name: _____ Date:_____

DOB:_____ EMAIL:_____

Address:_____

Primary Phone:_____ Secondary Phone:_____

EMERGENCY CONTACT

Name: _____ Relationship:_____Phone Number:_____

EMAIL:_____Secondary Phone Number:_____

How Did You Hear About Us?_____May we contact you about our specials/events**:** Yes/No

Health History

Physician Referral:_____ Phone:_____
Are you in Litigation for your pathology?_____ If so please provide us with all information required by your attorney

Current Medications:_____

Previous Injuries/Surgeries/Hospitalizations:_____

What is the reason for your visit today?_____

Do you have any pain?_____, If Yes location of Pain:_____
How would you rate your pain 0-10 (0 no pain<-> 10 emergency room)_____
Are you experiencing any of the following:Numbness__, Tingling___, Ache__, Burning__, Stabbing Pain__, Radicular Sx___

In the past 5 years have you experienced any and or have had any pathologies with the following? (Check all that apply):

Head__, Neck__, Arm__, Spine__, Hip__, Knee___, Ankle/Foot__, Heart__, High Blood Pressure__, Glaucoma__,
Asthma__, Emphysema___, Diabetes__, Hepatitis___, HIV__, Cancer___, Osteoporosis___, High Cholesterol___,
Are you pregnant (Yes/No)?_____

PLEASE LIST ANY OTHER SIGNIFICANT HEALTH HISTORY_____

_____

I Declare All Information Above is Accurate and to the Best of My Knowledge

_____
PRINT NAME

_____ DATE_____
SIGNATURE

_____ DATE_____
PARENT/LEGAL GUARDIAN (IF UNDER 18 YOA)

Please Complete Front and Back of Form, Signature Required

Release and Waiver

I,_____, have voluntarily enrolled in an exercise program and or rehabilitation exercise training program conducted by Capital Wellness located at 6701 Democracy Blvd, Ste 102, Bethesda MD 20817, including their satellite locations (off site visits), and agree to the following:

I understand participating in an exercise/rehabilitative exercise training program may involve strenuous physical activity. I hereby affirm that I have discussed exercise/rehabilitative program with my physician and have received permission from my physician to participate in a program of this nature.

I am aware that participating in such a exercise/rehabilitation program may cause injury to myself or negative impact to my physical condition, including but not limited to heart attacks, muscle strains, pulls or tears, broken bones, light-headedness, fainting, injuries to joints and any illness, soreness or injury however caused resulting from, occurring during, or occurring after my participation in the exercise/ rehabilitative program being provided by a Capital Wellness instructor/practitioner. I have been informed that the program involves possible risks and all exercises shall be taken at my sole risk and that neither Capital Wellness, nor the officers, directors, contractors, or employees shall be liable to me or any other person, for any claims, demands, injuries, damages, actions or causes of action, whatsoever, to my person or property arising out of or connected to services and/or exercises having direct relation to Capital Wellness. I voluntarily hereby indemnify and hold harmless, Capital Wellness, the officers, directors, contractors and their employees from any liability now and in the future, from all claims, demands, injuries, damages, actions,or causes of action and from all acts of active or passive negligence.

I Agree to and Understand the Above Statement

_____ _____

Print name Date

_____

Signature

_____ _____

Signature of Legal Guardian Date

Please Complete Front and Back of Form, Signature Required