

Health Screening Form



Name: _____ Age: _____
Address: _____ Postal Code: _____
Phone: _____ Date: _____

1. Are you currently exercising or physically active? No Yes

2. Describe your current exercise program / physical activity

3. Have you been diagnosed with osteoporosis? No Yes

4. Have you had a low-trauma fracture? No Yes

If yes, which bone was broken? (e.g., hip, wrist, ribs, spine, etc.) _____

5. Have you had a fall in the last 12 months No Yes

If Yes, was it indoors? No Yes

6. Has a doctor ever told you not to exercise? No Yes

7. Please check those conditions you have now, or have had in the past.

- Heart problems including chest pain with activity (angina)
- Stroke
- High blood pressure
- Other chronic illness (please outline below)
- Recent surgery
- Bronchitis, asthma or emphysema
- Significant joint problems
- Significant back pain that persisted
- Previous injury that is still affecting you
- Diabetes
- Smoking
- High cholesterol
- Heart problems in the immediate family
- Vision impairment
- Hearing impairment

Please put any additional comments here: _____
