Total Human Performance LLC

Functional Fitness Registration Form

Contact Information

Name of Participant _____ Cell Phone _____ Alternate Phone _____

Address _____ City, State _____ Zip _____

Email address _____ Date of Birth _____ Gender M __ F __

May we send text messages to for URGENT updates?
(You are responsible for text message charges that may be applied by cell phone provider) ☐ **YES** ☐ **NO**

Emergency Contact: Name _____ Phone _____ Relationship to you _____

Physician Name: Name _____ Phone _____ Address _____

Health History:

Step 1: Signs and Symptoms:

Do you experience (check all that apply):

- ☐ Chest discomfort with exertion
- ☐ Unreasonable breathlessness
- ☐ Dizziness, fainting, blackouts
- ☐ Ankle swelling
- ☐ Unpleasant awareness of a forceful, rapid, or irregular heart rate
- ☐ Burning or cramping sensations in lower legs when walking a short distance
- ☐ Known heart murmur

If you **marked** any of these statements under the symptoms, **STOP**, you should seek medical clearance before engaging in or resuming exercise. You may need to use a facility with **medically qualified staff**.

Step 2: Current Activity

Have you performed planned, structured, physical activity for at least 30 minutes at a moderate intensity on at least 3 days per week for the last 3 months?

☐ Yes ☐ No

Continue to step 3.

Step 3: Medical Conditions

Have you had or do you currently have (check all that apply):

- ☐ a heart attack
- ☐ heart surgery, cardiac catheterization, or coronary angioplasty
- ☐ pacemaker/implantable cardiac defibrillator/rhythm disturbance
- ☐ heart valve disease
- ☐ heart failure
- ☐ heart transplantation
- ☐ congenital heart disease
- ☐ diabetes – Type: _____
- ☐ renal disease
- ☐ angina
- ☐ lung disease: (type)_____
- ☐ stroke
- ☐ Alzheimer's/dementia
- ☐ muscle ☐ bone ☐ back ☐ head/neck disorder ☐ arthritis
- ☐ arthritis
- ☐ seizures
- ☐ asthma
- ☐ family history of heart disease in parents or siblings prior to age 55
- ☐ any conditions not list (please list): _____

Continue to back page - Medications

Health History continued

Medications

Check those medications that you are currently taking:

☐ blood pressure medication
☐ asthma medication
☐ heart medication
☐ other: _____

Other symptoms

Do you have any physical condition, impairment, or disability, including joint or muscle problems that limit your activities?
☐ Yes ☐ No ☐ Unknown

Have you ever had angina or heavy pressure in your chest as a result of exercise, walking, or other physical activity such as climbing a flight of stairs?
☐ Yes ☐ No ☐ Unknown

Participant signature: _____ **Date:** _____

Print name: _____