Cocozzo Physical Therapy

Accelerate Your Functional Movement

Name: Date:

Physician's Name: Phone#:

Person to Contact in Case of Emergency:
Name: Relationship: Phone#:

Are you taking any medication or drugs? What?

Does your physician know you are participating in this exercise program?

Describe your exercise program now:

Do you now, or have you had in the past:	Yes	No	
1. History of heart problems, chest pain or stroke	--___	___	
2. Increased blood pressure	___	___	
3. Any chronic illness or condition	___	___	
4. Difficulty with physical exercise	___	___	
5. Advice from physician not to exercise	___	___	
6. Recent surgery (last 12 months)	___	___	
7. Pregnancy (now or within the last 3 months)		___	___
8. History of breathing or lung problems	___	___	
9. Muscle, joint, or back disorder, or any previous injury still affecting you		___	___
10. Diabetes of thyroid condition		___	___
11. Cigarette smoking habit	___	___	
12. Obesity (more than 20% over ideal body weight)		___	___
13. Increased blood cholesterol		___	___
14. History of heart problems in immediate family	___	___	
15. Hernia, or any condition that may be aggravated by lifting weights		___	___
16. Please explain any yes answers on back			

Comments____
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