Health Screening Questionnaire

1. Have you had an annual checkup with you primary care physician in the last year?

   ◯ Yes ◯ No

2. Do you have any medical condition that might inhibit your ability to exercise safely?

   ◯ Yes ◯ No If yes, please specify____

   ____

3. Do you currently or have you previously had any musculoskeletal pain? Check all that apply.

   ◯ Neck ◯ Back ◯ Shoulder ◯ Elbow ◯ Wrist/Hands ◯ Hip ◯ Knee ◯ Foot/Ankle

   ◯ Other____

4. Do you currently have any difficulty or safety concerns with functional tasks such as yard/house work, walking on uneven ground or in crowed environments, or performing a structured exercise routine?

   ◯ Yes ◯ No If yes, please specify ____

5. Would you like to set up an evaluation with a Doctor of Physical Therapy to assess your physical condition and develop an individualized plan catered to the treatment and/or prevention of musculoskeletal pain and/or functional deficits?

   ◯ Yes ◯ No

6. What is your contact information and most convenient time to contact you to regarding you answers on this form?

   Phone: ___________________________________ Time: _____________am/pm

7. Name (please print): ____

   Signature:
   ____Date:_______________________

SCOTT RECREATION COMMISSION