Riverview Health Rehab & Fitness Personal Information

Last name | First name | Middle Initial

/ / DOB | ☐ Male | ☐ Female | E-mail

Street Address | City | State | Zip

( ) Best Contact Phone ☐ Home ☐ Cell ☐ Work

Emergency Contact:

Last | First | ( ) Phone | Relationship

Please check all that apply

☐ Fitness	☐ Class Member	☐ Pool Maintenance

Please check any that apply:

☐ RVH Employee /Volunteer RVH Plus One	☐ Silver Sneakers / Renew Active Silver & Fit	☐ Hamilton County School / Employee / Police / Fire
☐ RVH PT / OT Therapy	☐ Patient of RVH physician	☐ Body Knowledge Program
☐ College Student	☐ Veteran	☐ Meals on Wheels

Please answer the following questions to the best of your ability. All information will be kept confidential.

Heart problems, chest pain, or stroke?	☐ YES	☐ NO
Do you have high blood pressure?	☐ YES	☐ NO
Diabetes, thyroid or any other chronic illness or conditions?	☐ YES	☐ NO
History of breathing or lung problems?	☐ YES	☐ NO
Muscle, joint, or back disorder?	☐ YES	☐ NO

Please explain all "YES" answers and list any precautions or limitations stated by your physician:

_____

_____

Do you take medications for the following (please circle) and list medications:

Blood Pressure: _____ Stroke: _____

Cholesterol: _____ Heart: _____

Hospitalization in 5 years: _____

My primary care physician is: _____ Phone #: _____

Client or Parent/Legal Guardian Signature: _____ Date: ____/____/_____