

HEALTH SCREENING – PART 1

Age: _____

Height: _____

Weight: _____

Sex: _____

Stress (Check one): None___ Mild___ Severe:___

Daily activities (occupation):

Sleeping habits (Check One): Light Sleeper___ Normal___ Heavy___
Intermittent___

Most recent exercise program (Date and duration):

Water intake: _____

Have you been advised against exercise? _____

What are your long & short-term goals?

Parent/Guardian Init: