Medical History, Emergency Information & Health Care Consent

Client's Full Name:_____ Date of Birth:_____

Street Address,_____

City, State, Zip:_____

Phone(s): H:_____ W:_____ C:_____

Height:_____ Weight:_____ Tetanus Shot within the last 10 years: Yes [ ] No [ ]

Medications & Dosage	Taken Since	Prescribed by (Physician)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please check any areas of medical concern. If "yes," please explain in the Comments Section.

Areas	Yes	No	Comments
Auditory	☐	☐	_____
Visual	☐	☐	_____
Speech	☐	☐	_____
Cardiac (Heart)	☐	☐	_____
Circulatory (blood vessel disease)	☐	☐	_____
Pulmonary (lungs, breathing, asthma)	☐	☐	_____
Neurological (stroke, seizures)	☐	☐	_____
Muscular	☐	☐	_____
Orthopedic	☐	☐	_____
Allergies (drugs, bees, etc.)	☐	☐	_____
Learning disability	☐	☐	_____
Psychological impairment	☐	☐	_____
Diabetes (type 1 or type 2)	☐	☐	_____
Drug allergy/reactions	☐	☐	_____
Other	☐	☐	_____

By signing this form, I, _____ (please print client name) certify all information to be complete and true to the best of my knowledge.

Client's Name:_____ Date:_____

Client's Signature:_____ Date:_____