Pinnacle Volleyball Hawaii Health Questionnaire

All information in your health questionnaire is kept confidential. This questionnaire is important to evaluate any health or safety risks. Please inform us of any changes to the indicated conditions. It is recommended that any person engaging in regular physical activity should consult a physician prior to commencing exercise/training.

Last Name: _____ First Name: _____ Middle Initial: _____

Gender: M / F Date of Birth: _____ Age: _____ Height: _____ Weight: _____

Father's Name: _____ Phone #: _____ Occupation: _____

Mother's Name: _____ Phone #: _____ Occupation: _____

Emergency Contact: _____ Relation: _____ Phone #: _____

Physician: _____ Address: _____ Phone #: _____

Please read the questions carefully and answer accurately.

Has your doctor told you that you have a heart condition?	Yes	No
Do you feel pain in your chest when you do physical activity?	Yes	No
In the past month, have you experienced chest pain when NOT doing physical activity?	Yes	No
Do you experience dizziness, loss of balance, or loss of consciousness?	Yes	No
Do you take medication for blood pressure or heart conditions?	Yes	No
Do you have high blood pressure?	Yes	No
Have you ever had a stroke?	Yes	No
Do you have any tightness or pain in your chest, neck or arms?	Yes	No
Do you have any swelling of ankles, feet or hands?	Yes	No
Do you have a family history of heart disease, stroke, high cholesterol, high blood pressure?	Yes	No
Are you anemic?	Yes	No
Do you have lung disease?	Yes	No
Do you suffer from diabetes/epilepsy/asthma?	Yes	No
Are you pregnant, or have you given birth in the last six weeks?	Yes	No
Do you have, or have you had any illnesses recently?	Yes	No
Have you had surgery recently?	Yes	No
Have you had any problems with your back?	Yes	No
Do you have a bone, joint or lower back problem that may worsen by physical activity?	Yes	No
Do you have any orthopedic or muscular problems?	Yes	No
Do you have arthritis, bursitis?	Yes	No
Have you had foot or ankle problems?	Yes	No
Do you have any food or drug allergies?	Yes	No
Are you aware of any reason why you should not do physical activity?	Yes	No

If you answered "yes" to any of the questions above, please briefly explain your situation:

_____

_____

Please list all injuries in the past 5 years that required medical attention:

_____

_____

What type and how often do you engage in physical activity? (Past or present)

_____

What are your aims for volleyball?

_____

_____

I have read and I understand this questionnaire and confirm that I have answered all questions to the best of my knowledge. I understand that I will participate at my own risk and will waive any legal recourse for damages to myself or property arising from my participation.

CLIENT DECLARATION:

I understand and have answered all the questions honestly, and to the best of my knowledge. I understand that I should not participate in any physical activity if I feel unwell, and should inform my coach/instructor if my health changes during the course of the clinics.

Member Signature: _____ Date: _____

Parent Signature: _____ Date: _____

Staff Check: _____ Date: _____