Martha Lake Chiropractic & Wellness

MYORIDE

Clinical Fitness Application

Name: _____ Phone: _____

Email: _____

Address: _____State: _____ Zip: _____

General Health Questionnaire of clearance for the 4-Week Myoride Cardio Challenge

1. Do you have a heart condition? ☐ No ☐ Yes (explain) _____
2. Have you had a stroke? ☐ No ☐ Yes (explain) _____
3. Do you have high blood pressure? ☐ No ☐ Yes (explain) _____
4. Do you have breathing problems? ☐ No ☐ Yes (explain) _____
5. Should you only do physical activity recommended by a doctor? ☐ No ☐ Yes (explain)

_____

6. Do you feel pain in your chest when you do physical activity? ☐ No ☐ Yes (explain)

_____

7. In the past month, have you had chest pain when you were not doing physical activity?
☐ No ☐ Yes (explain) _____
8. Do you lose your balance because of dizziness or do you ever lose consciousness?
☐ No ☐ Yes (explain) _____
9. Do you have bone or joint problems (back, knee or hip) that are made worse by physical activity? ☐ No ☐ Yes (explain) _____
10. Are you taking prescription medication? ☐ No ☐ Yes (explain)

_____

11. Do you have any other health condition that we should note? ☐ No ☐ Yes (explain)

_____

12. When was the last time you exercised? ☐ within last 4 weeks ☐ longer than 4 weeks
13. Do you know of any other reason why you should not do our exercise program? ☐ No ☐ Yes (explain) _____

If you qualify, you will be placed in your first choice 4-week program. If you don't qualify right now we will keep your information on file.

Thank you for helping us help you!

Signature: _____ **Date:** _____