Medical History

Disclosure Statement

I understand that I must inform FCAP and David Luedeka DPT, CSCS and or his associates of any conditions or disorders that could interfere with my treatment, e.g. heart condition, diabetes, high blood pressure, etc. I will inform my therapist or trainer of any medical conditions(s) that I now have or have had in the past.

I understand that if, at any time during the course of my therapy or training, I am unsure as to the proper use of equipment, I will stop immediately and consult a staff member for further instructions.

_____ _____

Signature of Client or Parent or Guardian Date

_____

Printed Name

Check appropriate boxes and note diagnosis in the area provided:

Cardiac
- High blood pressure □
- Dyslipidemia □
- Arrhythmia □
- M.I. □
- Other □

_____

Orthopedic
- Sprain □
- Strain □
- Fracture □
- Scoliosis □
- Osteoarthritis □
- Other □

_____

Respiratory
- Asthma □
- Other □

_____

Allergies
- Seasonal □
- Latex □
- Other □

_____

Endocrine
- Diabetes □
- Thyroid dysfunction □
- Other □

_____

Vascular
- PVD □
- Other □

_____

Neurological
- Developmental □
- Cerebral Palsy □
- Radiculopathy □
- CVA □
- Bowel or Bladder Dysfunction □
- Other □

_____

General Health
- Unexplained Weight Loss □
- History of Cancer □
- Severe unexplained pain □
- Recent Illness / Infection □
- Recent Surgical Procedure □

Medications (May also attach on separate list)

Medication	Purpose

_____

Client / Parent / Guardian initial and date