Health History Form
The Hope Chest Exercise and Dragon Boat Program
New Members

* **Please be advised all information is kept strictly confidential**

Today's Date: ______________________

Participant's Name: ____
Last First

Address:____

City/Town:____________________________________ Zip Code:________________

Email: ____

Phone: H:______________________C:_______________________W:______________________

Emergency Contact Name:______________________________________Relationship______________

Emergency Contact Number: H:___________________C:________________W:______

Do you have physician's approval to exercise? Yes or no (circle one)

Date of Birth:____________________

Breast Cancer History:

1. Date of Diagnosis:______________________
2. Please Circle any/all treatments: Surgery Chemotherapy Radiation
3. Did Surgery or radiation occur on: Right Side Left Side Both Sides (circle one)
4. If you had surgery was the procedure: Lumpectomy Mastectomy (circle one)
5. Are you currently on any breast cancer related medications? Please list:
   a. __________________________________
   b. __________________________________
6. Are you experiencing any discomfort or limitations due to your treatment or medications? Please explain:

____

7. Have you exercised since your treatment? Yes No (circle one)

   If yes, when did you begin to exercise? ________________________

8. General History:

a. Please check any of the following conditions that apply to your health:

☐	Arthritis	☐	Heart Problems	Hip Replacement R/L
☐	Asthma	☐	High Blood Pressure	Knee Replacement R/L
☐	Diabetes	☐	High Cholesterol	Other_________________
☐	Epilepsy	☐	Stroke	

b. Do you have pain or discomfort in any of these areas? Please check that apply

☐	Neck	☐	Lower Back
☐	Elbows	☐	Knees
☐	Wrists	☐	Shoulders
☐	Hips	☐	Upper Back

Please give further description:

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c. Please list any over the counter or prescription medications you are taking, including any supplements:

Medications:

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____

____

____

Supplements:

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____

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d. Are you currently undergoing treatment from any of the following? (please circle)

Physical Therapist Chiropractor Massage Therapist