



## Personal Information & Health Data Questionnaire

Please print clearly.

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Occupation/Company: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_

City/Zip: \_\_\_\_\_

Home Phone: ( ) \_\_\_\_\_ (Please asterisk best contact number.)

Work Phone: ( ) \_\_\_\_\_

Mobile Phone:( ) \_\_\_\_\_

E-Mail: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_

Relationship: \_\_\_\_\_ Contact Number: \_\_\_\_\_

T-Shirt Size: S M L XL 2X

Do you give permission to share your name and email address with other school participants and/or Network members? YES NO

Do you waive ownership of any photographic records taken by Janes on the Run and agree to permit the use of your image, (in photograph, digital, or electronic form) for web site or other promotional media? YES NO

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Blood Pressure: \_\_\_\_\_ (If known.)

If not currently active, list date last participated in an exercise program: \_\_\_\_\_

If active, how long have you been exercising? \_\_\_\_\_

| Current Activity (including running) | Duration | Frequency |
|--------------------------------------|----------|-----------|
| _____                                | _____    | _____     |
| _____                                | _____    | _____     |
| _____                                | _____    | _____     |

Date of last physical exam: \_\_\_\_\_

Physician's Name: \_\_\_\_\_

Physician's Phone: \_\_\_\_\_

**Check any of the health conditions/risks that apply to you:**

- |   |                                   |  |
|---|-----------------------------------|--|
| _____ allergies                         | _____ unusual dizziness/fainting* | _____ osteoporosis                               |
| _____ asthma                            | _____ unusual fatigue*            | _____ pregnant*                                  |
| _____ arthritis                         | _____ heart problems*             | _____ sedentary lifestyle                        |
| _____ cancer                            | _____ high blood pressure         | _____ seizure disorder                           |
| _____ cigarette smoker<br>(past 6 mos.) | _____ high cholesterol            | _____ surgery (w/i 3 mos.)                       |
| _____ diabetes                          | _____ orthopedic concerns         | _____ shortness of breath<br>w/usual activities* |

\_\_\_\_\_ Other (Please specify.): \_\_\_\_\_

\_\_\_\_\_ Family history of heart disease? If yes, please explain. \_\_\_\_\_

**Please note any physical limitations or injuries:**

Past \_\_\_\_\_

Present \_\_\_\_\_

**Do you take any medications that will affect you when exercising?** Yes No

If yes, please explain. \_\_\_\_\_

**Do you know of any other reason why you should not engage in physical activity?** Yes No

If yes, please explain. \_\_\_\_\_

The information gathered will only be used in making recommendations for your training program. It is strongly recommended that you seek physician's clearance before beginning this or any exercise program. The coaching guidance provided by Janes on the Run is not intended in any way to substitute for professional medical advice. Always seek the guidance of your physician or other qualified health provider with any questions you may have regarding a medical condition. Neither the content of this document nor any service by Janes on the Run is intended to be relied on for medical diagnosis or treatment.

I have reviewed these questions and answered them to the best of my ability. I understand the information will be reviewed and I may be asked to see my doctor before participating in a Janes on the Run Training Program.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

(Signature of parent if under 18)