

Revolution Parkour
Medical Questionnaire and Client Information Sheet

Name: _____		Date: _____	
_____	First	Last	
Address: _____			
City: _____	State: _____	Zip: _____	
Home Phone: _____		Work Phone: _____	
Email: _____			
Date of Birth: ____ / ____ / ____		Sex: M F	Height: ____ Weight: ____

How did you hear about Revolution Parkour? _____

Why did you choose to enroll in a Revolution Parkour course?: _____

Do you have any fitness goals?: _____

Occupation: _____

Current Activity Level: Low Medium High

Daily Activity (in hours): Sitting _____ Standing _____ Moving _____

Training/Sports/Exercise:

Type: _____	Freq: _____	Dur: _____
Type: _____	Freq: _____	Dur: _____
Type: _____	Freq: _____	Dur: _____
Type: _____	Freq: _____	Dur: _____
Type: _____	Freq: _____	Dur: _____

Do you have any current physical conditions? Yes No

If Yes, please describe: _____

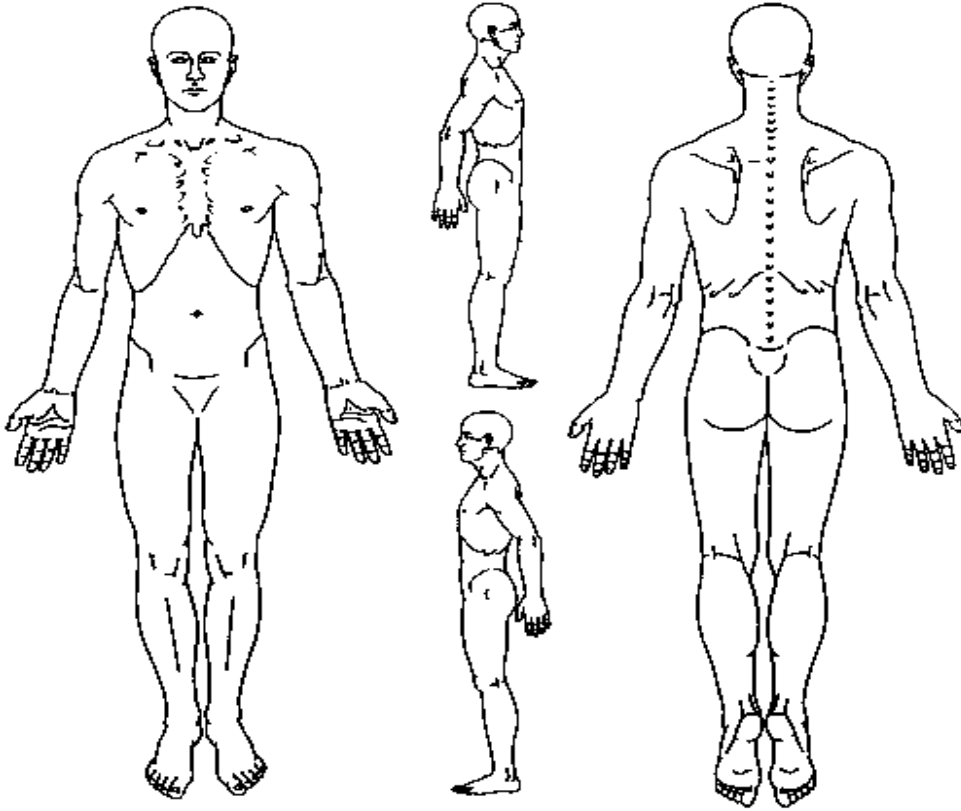
Current Symptoms: (S = Sharp, D = Dull, T = Throbbing, A = Achy, R = Radiating)

Upper: R L Both - Shoulder/ Elbow/ Wrist	_____
Upper: R L Both - Shoulder/ Elbow/ Wrist	_____
Spine: R L Both - Cervical/ Thoracic/ Lumbar	_____
Spine: R L Both - Cervical/ Thoracic/ Lumbar	_____
Lower: R L Both - Hip/ Knee/ Ankle	_____
Lower: R L Both - Hip/ Knee/ Ankle	_____

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Please mark where you are currently feeling symptoms. Write in descriptions of your symptoms (for example: sharp, dull, aching, radiating, shooting, throbbing, tingly, numb) and rate the intensity of symptoms from 1 -10.



Past Injuries/Surgeries:

Upper: R L Both - Shoulder/ Elbow/ Wrist _____

Upper: R L Both - Shoulder/ Elbow/ Wrist _____

Spine: R L Both - Cervical/ Thoracic/ Lumbar _____

Spine: R L Both - Cervical/ Thoracic/ Lumbar _____

Lower: R L Both - Hip/ Knee/ Ankle _____

Lower: R L Both - Hip/ Knee/ Ankle _____

Signature of Participant or if applicable, Parent or Legal Guardian of Participant.	
Print name of Participant	Date Executed