CBI Health Client Health Screen

Client Name: _____ Client Date of Birth _____

Gender ◯ Male ◯ Female ◯ Other

ID Verified (therapist use only) ☐

Primary Physician Name: _____ Contact # _____

Lawyer Name: _____ Contact # _____

Emergency Contact Name: _____ Contact # _____
Relationship:

Please check the boxes for all that apply below:

1. Has your doctor ever said you have heart trouble? ☐
2. Do you frequently have pains in your heart and chest? ☐
3. Do you ever feel faint or have spells of severe dizziness? ☐
4. Have you ever had a seizure? ☐
5. Have you ever been told that your blood pressure is too high? ☐
6. Do you experience difficulty breathing when resting? ☐
7. Do you have a history of asthma, emphysema or COPD? ☐
8. Do you have a persistent cough? ☐
9. Have you had a recent viral infection? ☐
10. Have you had any surgery in the past 12 months? ☐
11. Do you have any problems with swelling in your legs or feet? ☐
12. Are you currently on any medications? ☐
13. Is there any medication you are supposed to be taking that you are not taking? ☐
14. Is there a reason that you should not follow an activity/ exercise program that is not mentioned here? ☐
15. Has stress negatively affected your work/life balance in the past 6 months? ☐
16. Have you ever experienced a significant weight loss or gain in the past 60 days? ☐
17. Have you ever been diagnosed with depression or anxiety? ☐
18. If female, are you pregnant? ☐

Have you had/Do you have any of the following? (please check all that apply)

19. Diabetes ☐	20. Bowel problems ☐	21. Bladder problems ☐
22. Rheumatoid Arthritis ☐	23. Epilepsy ☐	24. Blackouts ☐
25. Circulation problems ☐	26. Pacemaker ☐	27. Blood clots ☐
28. Current fatigue or nausea ☐	29. Cancer (either past or present) ☐	30. Osteoporosis ☐
31. Metal pins, plates or screws inserted into a bone ☐		

32. Do you have any allergies or conditions not listed? ☐
(If so, please provide details below)

In case of medical emergency, do you have any special instructions for your therapist?

Please list below any prescribed medications you are taking

Prescribed Medication	Dosage	Prescribing Physician	
		Name	Phone Number

Client Signature Date:

Therapist Signature Date: