

GARY H. LINDAHL, P.T.
Member American Physical Therapy Association
Member of SuperSlow® Guild, Inc.

Consultant/Educator
Ergonomic Analysis
Low Back Education
SuperSlow® Master
Certified Level II

Information Form

General Information

Name _____ Address _____ Birthdate _____
City _____ State _____ Zip _____ Sex _____
Email _____

Phones (circle the best number to reach you)

Home _____ Business _____ Cell _____

Occupation _____

In case of emergency, call Name _____ Phone _____

Personal Physician:

Name _____

Address _____

Phone _____

Health Analysis

Circle Yer or No. If yes, please explain

When was your last physical? Date _____

Are you under a physician's care now? Yes No Explain _____

Are you taking a physician prescribed or over the counter medications? Yes No Explain _____

Do you want me to coordinate your exercise program with a physician? Yes No Explain _____

Name _____

Address _____

Phone _____

Have you had any recent major illnesses? Yes No Explain _____

Have you had a major or minor (outpatient) surgery in the last 5 years? Yes No Explain _____

Do you have or have you ever had high or low blood pressure? Yes No Explain _____

Do you or any of your family have any history of aneurysms or sudden cardiac deaths? Yes No Explain _____

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Are you under a physician's care, special diet, or medication? Yes No Explain _____

Do you experience frequent headaches? Yes No Explain _____

Do you have diabetes? Yes No Explain _____

Do you have low back or neck pain, tension or fatigue? Yes No Explain _____

Do you have any joint pain (shoulders, elbow, wrists, hips, ankles, etc.)? Yes No Explain _____

Are you aware of any abdominal hernias, or have you had one repaired in the past? Yes No Explain _____

Can you think of anything to add which I might need to know in order to keep your exercise sessions safe and productive? _____

Exercise Goals and Concerns

What exercise and/or recreational activities are you engaged in currently? _____

How would you rate your current level of physical fitness? _____

Which exercise goals and/or results are most important to you? Check **all** that apply:

- | | |
|---|---|
| <input type="checkbox"/> Fat Loss/Improved Body Shape | <input type="checkbox"/> Increased Muscular Size and Strength |
| <input type="checkbox"/> Cardiovascular Conditioning and Health | <input type="checkbox"/> Improved Athletic Performance |
| <input type="checkbox"/> Relief from Pain? Area | <input type="checkbox"/> Physical Rehabilitation |
| <input type="checkbox"/> Increased Muscular Endurance/Energy | <input type="checkbox"/> Increased Bone Strength/Density |
| <input type="checkbox"/> Improved Flexibility | |

The above statements are true and complete to the best of my knowledge, and hereby authorize Gary Lindahl, P.T. to release information to my physician, or to request from my physician any pertinent information regarding any physical condition that I have indicated above.

Signed _____ Date _____