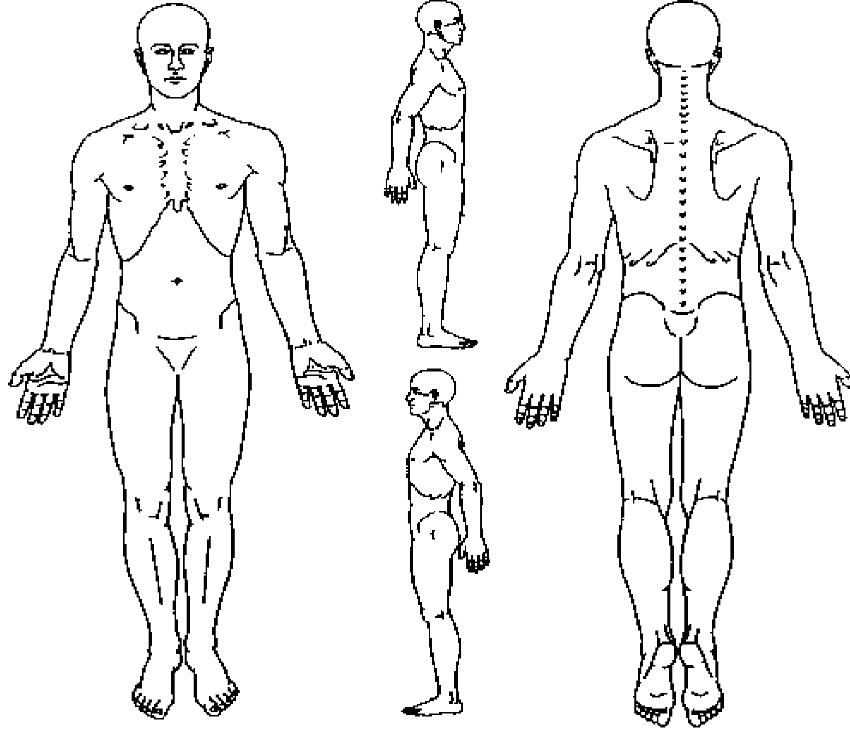
LIC GYMNASTICS
Medical Questionnaire

Please circle where you are currently feeling symptoms. Write a description of your symptoms (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 ____________________

Current Activity Level: Low Medium High

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

Training / Sports / Exercise:

Type: __________ Frequency: __________ Duration: __________
Type: __________ Frequency: __________ Duration: __________
Type: __________ Frequency: __________ Duration: __________

Do you have any current physical conditions? Yes No

If Yes, please describe:____

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Print Name of Participant	Signature of Participant or Legal Guardian	Date Executed