EARTHWAYS LLC CONFIDENTIAL HEALTH QUESTIONNAIRE

(No answer to any question will automatically disqualify you from this program.)

TODAY'S DATE:_____ NAME AND DATES OF PROGRAM: _____

NAME:_____ BIRTHDATE: _____

ADDRESS: _____

CELLPHONE (for use on day of group's arrival): _____ HOME PHONE: _____

1.	Do you wear a Medi-Alert Tag?	□ Yes □ No
2.	Were you hospitalized in the last five years?	□ Yes □ No
3.	Do you have allergic or anaphylactic reactions from foods, drugs, insect bites or stings?	□ Yes □ No
4.	Have you ever experienced a seizure of any kind?	□ Yes □ No
5.	Do you have heart or lung disease of any kind?	□ Yes □ No
6.	Do you have hemophilia or any other disorder that impairs blood-clotting?	□ Yes □ No
7.	Do you have any muscle, joint, or bone related injuries or disabilities?	□ Yes □ No
8.	Do you have trouble with headaches or other neurological problems?	□ Yes □ No
9.	Do you have hypoglycemia or diabetes?	□ Yes □ No
10.	Do you have any other chronic disease that, in any way, threatens your health? If yes, what is it?	□ Yes □ No
11.	If you walked on the level for a mile at an average pace would you get out of breath, have pains in the chest, develop muscle fatigue or have pains in your legs?	□ Yes □ No
12.	Are there any reasons you should not fast or live alone?	□ Yes □ No
13.	If you are under the care of a physician and/or therapist, would they have concerns about you attending this program?	□ Yes □ No
<u>If answered yes to any of the above questions, please describe in more detail here – or use the back of this page</u>:		
14.	Are you taking <u>any</u> medication at present time? If yes, what are they?	□ Yes □ No
15.	Any dietary preferences or needs? If yes, please describe: _____	□ Yes □ No
16.	Have you been infected with COVID? If yes, when? _____ If yes, any persistent symptoms? Please describe: _____ Have you completed a full course of a COVID vaccine? If yes, the date: _____ _____	□ Yes □ No □ Yes □ No □ Yes □ No
17 .	Have you had a tetanus shot in the last 10 years? If yes, the date: _____	□ Yes □ No

SIGNATURE: _____ (If under 18 years old, signature of parent or guardian required.)

FOR EMERGENCY USE:

Your doctor's name: _____ Phone number: _____

Medical Insurance Co.:_____ Group/Policy No.: _____

In case of emergency, notify: Name:_____ Relationship: _____ Phone: _____