PHYSICAL EXAMINATION

(To be completed by Physician/ Licensed Practitioner)

Name _____

DOB _____ SSN: _____

Address _____

City_____ ST_____ ZIP _____

Height _____ Weight _____

General Appearance_____

Vision _____

Corrective Lenses? _____

Hearing _____ Blood Pressure_____

Laboratory and other Special Findings _____

_____

Convulsions/ Seizures?_____ Allergies _____

Any activities that should be restricted?_____

Medications_____

_____

Any reason this individual cannot participate in Joyful Heart Training Center program?

_____

Physician/Practitioner Name_____

Address _____

License #:_____State_____

Physician/ Practitioner Signature_____

Date_____

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