

MAIN DIAGNOSIS

SECONDARY DIAGNOSIS (TRANSMISSIBLE PATHOLOGY)

MEDICAL HISTORY : In the past, has the patient suffered any of the following

- | | | | | |
|--|---|---------------------------------------|--|--|
| <input type="checkbox"/> Cardio-vascular | <input type="checkbox"/> Muscular | <input type="checkbox"/> Bone-related | <input type="checkbox"/> Pulmonary | <input type="checkbox"/> Articular |
| <input type="checkbox"/> Dizzyspells | <input type="checkbox"/> Blood pressure | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Nervous system | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Diabete | <input type="checkbox"/> Fainting | <input type="checkbox"/> Eyesight | <input type="checkbox"/> Infections | <input type="checkbox"/> Hearing/auditive disability |
| <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> Incontinence | <input type="checkbox"/> Allergies | <input type="checkbox"/> Intellectual disability | <input type="checkbox"/> Psychiatric disability |

WHAT FUNCTIONAL LIMITATIONS ARE RESULTING FROM THIS (THESE) DIAGNOSIS?

IN YOUR OPINION, ARE THERE ANY CONDITIONS WICH MAY LIMIT THIS PERSON'S PARTICIPATION IN AN ADAPTED PHYSICAL ACTIVITY PROGRAM ?

yes _____ no _____ **IF YES, PLEASE INDICATE WHICH LIMITATIONS**

IS THE PATIENT TAKING ANY MEDICATION THAT COULD AFFECT HIS PHYSICAL TRAINING?

yes _____ no _____ **IF YES, PLEASE INDICATE WHICH MEDICATION**

COMMENTS:

DOCTOR IDENTIFICATION

Date: _____

NAME: _____

Address: _____ Telephone: () _____

Signature: _____ Practice number: _____