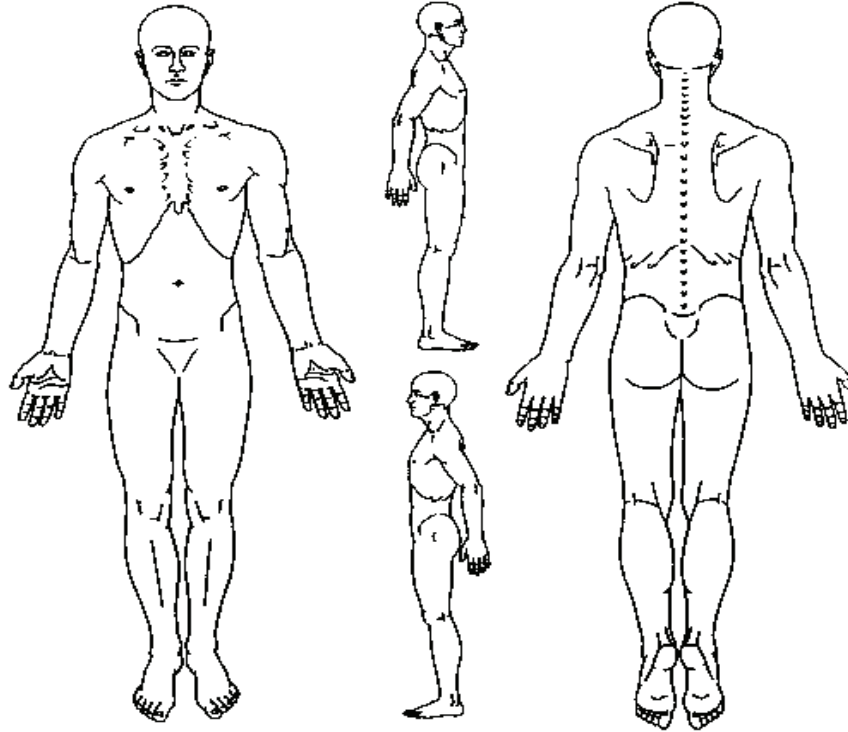




# Revolution Parkour Medical Questionnaire

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: \_\_\_\_\_

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