

## CONFIDENTIAL HEALTH QUESTIONNAIRE

DATE: \_\_\_\_\_ PROGRAM: \_\_\_\_\_  
 NAME: \_\_\_\_\_ TELEPHONE: \_\_\_\_\_  
 ADDRESS: \_\_\_\_\_  
 E-MAIL: \_\_\_\_\_  
 AGE: \_\_\_\_\_ DATE /TIME YOU EXPECT TO ARRIVE FOR THIS PROGRAM: \_\_\_\_\_

**FOR EMERGENCY USE:**

Your doctor's name: \_\_\_\_\_ Phone number: \_\_\_\_\_  
 Medical Insurance Co.: \_\_\_\_\_ Group/Policy No.: \_\_\_\_\_  
 In case of emergency notify: Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Does your doctor know you are going to participate in this retreat:  Yes  No  
 Does your emergency contact person know you will participate:  Yes  No

1.	Are you under the care of a physician? Would your physician disapprove of you entering this activity?      If yes, please describe why: _____ _____	<input type="checkbox"/> Yes <input type="checkbox"/> No  <input type="checkbox"/> Yes <input type="checkbox"/> No
2.	Are you seeing a therapist at present? Would your therapist disapprove of you entering this activity?      If yes, please describe why: _____ _____	<input type="checkbox"/> Yes <input type="checkbox"/> No  <input type="checkbox"/> Yes <input type="checkbox"/> No
3.	Do you have any history of emotional or psychological problems?      If yes, please describe: _____ _____  Please list any medications you are taking for psychological problems: _____ _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
4.	Are there any reasons why you should not fast or live alone?      If yes, please describe: _____ _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
5.	Do you wear a Medic-Alert Tag or any other marker of a medical problem? If yes, please describe: _____ _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
6.	Were you hospitalized in the last two years?      If yes, please describe: _____ _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
7.	Have you ever had a heart attack of any kind, or been told by a doctor that you have high blood pressure, a heart murmur or heart disease?      If yes, please describe: _____ _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
8.	Have you ever experienced a seizure of any kind?      If yes, please describe: _____ _____	<input type="checkbox"/> Yes <input type="checkbox"/> No

	Do you have allergic or anaphylactic reactions to any insults, such as environmental substances, foods, drugs, insect bites or stings? If yes, please describe: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
10.	Do you have hemophilia or any other disorder that impairs blood clotting? If yes, please describe: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
11.	Do you have a lung disease or any kind of breathing problem? If yes, please describe: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
12.	Do you have any muscle, joint, or bone related disabilities or limitations? If yes, please describe: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
13.	Do you have trouble with headaches? If yes, please describe: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
14.	Do you have any kidney disease? If yes, please describe: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
15.	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? Describe your degree of fitness in your own words: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
17.	Do you have hypoglycemia or diabetes? If yes, please describe: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
18.	Do you have any other chronic disease that, in any way, threatens your health? If yes, please describe: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
19.	Are you taking <u>ANY</u> medication at the present time, including allopathic, homeopathic or herbal? If yes, specify each drug, the dose and the reason for taking: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
20.	Any dietary preferences or needs? If yes, please describe: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
21.	When was your last tetanus shot? _____	

This information is accurate and complete. I agree to cooperate with the retreat facilitators to design a wilderness practice with full consideration of my health history and health concerns.

SIGNATURE: \_\_\_\_\_

(If under 18 years old, must be parent or guardian's signature)

**EarthWays**  
[admin@earthways.info](mailto:admin@earthways.info)  
[www.earthways.info](http://www.earthways.info)