



STABLE-SPIRIT

MEDICAL HISTORY

Participant: _____ DOB: _____ Height: _____ Weight: _____

Address: _____

Any Illnesses Diagnosed: _____

Past/Prospective Surgeries: _____

Medications: _____

Special Precautions/Needs: _____

Impairments in Dexterity, Flexibility, Movement: _____

Completed by (please print): _____

Signature _____ Date _____