



## Forest Therapy For Me

Exploring Nature's  
Healing Power

### Health Questionnaire

Date: \_\_\_\_\_

Full Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_

email: \_\_\_\_\_

Phone: \_\_\_\_\_ Alt Phone: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_

Physician Phone number: \_\_\_\_\_

Medical Insurer \_\_\_\_\_ Group | Policy No \_\_\_\_\_

Emergency Contact: \_\_\_\_\_

Relationship: \_\_\_\_\_

Phone: \_\_\_\_\_ Alt Phone: \_\_\_\_\_

Does your doctor know you are going to participate in this program:  Yes  No

Does your emergency contact person know you will participate:  Yes  No

Do you wear a Medic-Alert Tag or any other marker of a medical problem?  Yes  No

If yes, please describe:

Do you have allergic or anaphylactic reactions to any insults, such as environmental substances, foods, drugs, insect bites or stings?  Yes  No

If yes, please describe, and let us know if you carry an Epi pen or other fast-acting medication:

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?  Yes  No

Describe your degree of fitness in your own words:

Do you have any other health-related disease, condition, or concern that program guides should be aware of?  Yes  No

If yes, please describe:

### **Signature**

This information is accurate and complete. I agree to communicate fully with program instructors and Guides any health concerns that may arise. I give my permission to staff of the Association of Nature and Forest Therapy Guides to seek emergency medical diagnosis or treatment for me in the event that I am unconscious or unable to make my own decisions. I understand that should I need medical care for any reason while participating in this program the role of Guides will be limited to emergency first-aid and either transportation to the nearest medical facility, or contacting such a facility to arrange emergency transport.

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