Health Risk Assessment

Thank you for your submission.

This form must be printed through your web browser, signed, and returned to:

LeAnn Stricklin  
Student Wellness Center  
3410 Taft Blvd. Wichita Falls, TX 76308

I understand this Health Risk Assessment Questionnaire has been provided to me for the purpose of helping me better understand any potential risks associated with a workout program. I also understand I should share this information with my physician and seek his or her approval prior to beginning an exercise program. My signature signifies that all of above is true, to the best of my knowledge. Any information left unanswered was done so intentionally.

Signature: ________________________ Date: ________________________

Received by: ________________________ Date________________________