DATE: _____ AGE: _____

NAME:_____ DATE OF BIRTH: _____

ADDRESS: _____
Street City State Zip

CONTACT: _____
Home Phone Cell Phone Work Phone Email Address

OCCUPATION/EMPLOYER: _____

PHYSICIAN NAME & CONTACT INFO (PHONE/ADDRESS): _____

REASON FOR LAST DOCTOR VISIT? _____ DATE OF LAST PHYSICAL EXAM: _____

MEDICAL TESTS IN PAST YEAR (CIRCLE): Angiogram / Blood Test / CT Scan / EKG / Echo Test / MRI / Stress Test

EMERGENCY CONTACT: _____
Name Phone Relationship

Please provide responses (YES or NO) to the following concerning family history, personal history and symptoms:

FAMILY HISTORY
Have any immediate family members had a:

	YES	NO
Heart attack	O	O
Heart surgery	O	O
Coronary stent	O	O
Cardiac catheterization	O	O
Congenital heart defect	O	O
Stroke	O	O

Other chronic disease:
_____
_____
_____
_____

PERSONAL HISTORY
Have you ever had:

	YES	NO
High blood pressure	O	O
High cholesterol	O	O
Diabetes	O	O
Any heart problems	O	O
Disease of arteries	O	O
Thyroid disease	O	O
Lung disease	O	O
Asthma	O	O
Cancer	O	O
Kidney Disease	O	O
Heptatitis	O	O

Other: _____
_____

SYMPTOMS
Have you ever had:

	YES	NO
Chest pain	O	O
Shortness of breath	O	O
Heart palpitations	O	O
Skipped heartbeats	O	O
Heart murmur	O	O
Intermittent leg pain	O	O
Dizziness or fainting	O	O
Fatigue - usual activity	O	O
Snoring	O	O
Back pain	O	O
Orthopedic problems	O	O

Other: _____
_____

Are you taking any prescription medications? Yes □ No □
Are you taking any non-prescription medications or nutritional supplements? Yes □ No □
If yes to either of the above, please provide the following information for your current medications and/or supplements:

MEDICATION/SUPPLEMENT Dosage – Times/Day Time Taken Years on Med/Suppl Reason for Taking
_____
_____
_____

HOSPITALIZAIONS: Please list any recent hospitalizations

Year Location Reason
_____
_____
_____

Any other medical problems/concerns not already identified? Yes □ No □ If so, please list: _____

_____

_____

LIFESTYLE HABITS & EATING PATTERNS

Do you ever have an uncomfortable shortness of breath during exercise or when doing activities? Yes □ No □
Do you ever have chest discomfort during exercise? Yes □ No □ If so, does it go away with rest? Yes □ No □

Do you currently smoke or use tobacco products? Yes □ No □ If so, for how long: _____ years
How much per day? < ½ pack □ ½ to 1 pack □ 1 to 2 packs □ > 2 packs □
Have you quit smoking? Yes □ No □ If yes, when did you quit: _____

Do you drink any alcoholic beverages? Yes □ No □ If yes, how many in 1 week (indicate below):

Beer _____ (can/bottle) Wine _____ (glasses) Hard liquor _____ (drinks)

Do you drink any caffeinated beverages? Yes □ No □ If yes, how much in 1 week (indicate below):

Coffee _____ (cups) Tea _____ (cup/glass) Soft drinks _____ (cans) Energy Drinks _____ (cans)

How many times do you eat per day? (meals/snacks): 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7+ □

For the next few questions below, one glass or serving = size of your fist

How many glasses of water do you drink per day? 1-3 □ 4-6 □ 7-9 □ 10-12 □ 13-15 □ 16+ □ (= 1 gallon +)

How many pieces/servings of fruit do you eat per day (piece or serving)? 1-2 □ 3-4 □ 5-6 □ 7-8 □ 9-10 □ > 10 □

How many servings of vegetables do you eat per day? 1-2 □ 3-4 □ 5-6 □ 7-8 □ 9-10 □ > 10 □

Do you avoid any particular foods? If so, which, and why? _____

Do you eat anything in particular before or after a workout? If so, what? _____

Have you used weight reduction diets in the past? If yes, how often and what type(s)? _____

Approximately, what was your weight: Last year:_____ 3 years ago: _____ 5 years ago: _____

When you're inactive, do you tend to gain or lose weight? Gain □ Lose □ Neither □

Are you satisfied with your current weight and body composition? Yes □ No □

ACTIVITY LEVEL EVALUATION

What is your occupational activity level? Sedentary □ Light □ Moderate □ Heavy □

What sports have you previously, or currently participate in? _____

On average, how many hours do you spend seated per day: 1-3 □ 4-6 □ 7-9 □ 10+

On average, how many hours of sleep do you get a night: < 4 □ 4-5 □ 5-6 □ 6-7 □ 7-8 □ 8-9 □ 9+ □

Do you currently engage in vigorous physical activity on a regular basis? Yes □ No □

If so, how much time do you spend on each type of activity, *per week*:

	Time	Activities (details appreciated)
Cardiovascular training:		
Strength training:		
Flexibility training:		
Sports-specific activities:		

Your fitness goals and objectives are: _____

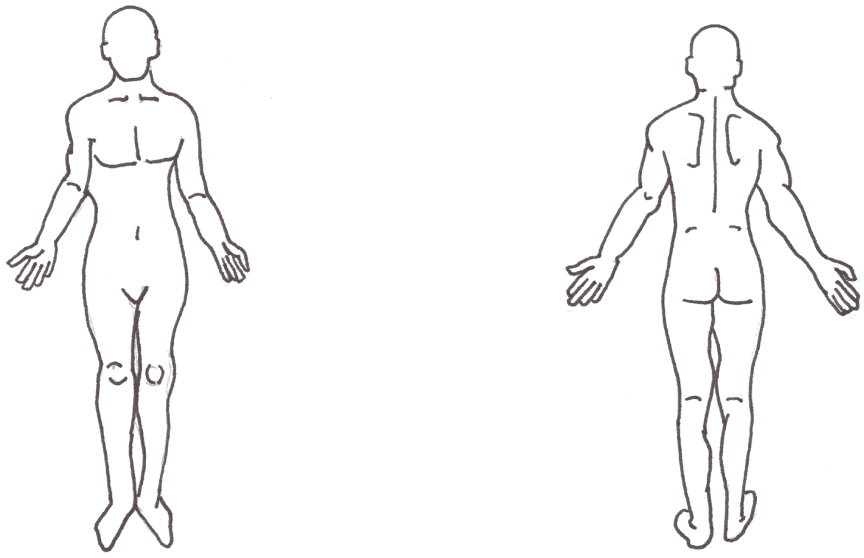
_____

ORTHOPEDIC HISTORY

Please include any major **musculoskeletal injuries and/or surgeries** in the following areas. Please include sprains, strains, dislocations, fractures, arthritis, bursitis or tendonitis.

Area			Date	Injury Type	Outcome
Foot	❒ Right	❒ Left	_____	_____	_____
Ankle	❒ Right	❒ Left	_____	_____	_____
Lower Leg	❒ Right	❒ Left	_____	_____	_____
Knee	❒ Right	❒ Left	_____	_____	_____
Thigh	❒ Right	❒ Left	_____	_____	_____
Hip/Pelvis	❒ Right	❒ Left	_____	_____	_____
Spine			_____	_____	_____
Torso			_____	_____	_____
Shoulder	❒ Right	❒ Left	_____	_____	_____
Upper Arm	❒ Right	❒ Left	_____	_____	_____
Forearm	❒ Right	❒ Left	_____	_____	_____
Wrist	❒ Right	❒ Left	_____	_____	_____
Hand	❒ Right	❒ Left	_____	_____	_____
Neck			_____	_____	_____
Head			_____	_____	_____
Other	❒ Right	❒ Left	_____	_____	_____

BODY DIAGRAM



Do you understand that you are taking a risk whenever you undertake an exercise program? ❒ NO ❒ YES

I declare the above information on all four pages of this Client Intake Form is to be accurate, correct, and a true reflection of my (or my minor's) physical condition.

Signature _____ Date _____