CLIENT INTAKE FORM

Name: ______________________________________ Date: ______________

Address: ____________________________________ State: ____ Zip: _________

Phone: Home ________________ Cell ______________ Work ______________

Occupation: ____

DOB: ______________ Age: ______ Sex: ______ Height: __________ Weight: _________

Emergency Contact: _______________________________ Phone: _____________

PHYSICIAN INFORMATION

Physician's Name: ____

Has your physician referred you to an exercise program? Yes ____ No ____

Has your physician cleared you to exercise? Yes ____ No ____ No physician comment ______

PERSONAL HEALTH HISTORY

Do you or any member of your immediate family have a history of:

	SELF	FAMILY
Asthma	( )	( )
Emphysema	( )	( )
Bronchitis	( )	( )
Other respiratory condition	( )	( )
Hypertension	( )	( )
Hypotension	( )	( )
Anemia	( )	( )
Osteoporosis	( )	( )
Tuberculosis	( )	( )
Hepatitis	( )	( )
Kidney Disease	( )	( )
Cancer	( )	( )
(specify type & location)		

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	SELF	FAMILY
Gastrointestinal Problems	( )	( )
Heart Condition	( )	( )
Pacemaker	( )	( )
Arthritic Condition	( )	( )
Bowel/Bladder Dysfunction	( )	( )
Unexplained Weight Loss/Gain	( )	( )
Shortness of Breath	( )	( )
Seizure Disorder/Epilepsy	( )	( )
Severe Headaches	( )	( )
Hypoglycemia	( )	( )
Diabetes	( )	( )
Stroke	( )	( )
Other (specify)	( )	( )

GENERAL HEALTH STATUS

Please read this questionnaire thoroughly. Please circle the appropriate answer.

1. **YES** **NO** Are you hard of hearing?
2. **YES** **NO** Has your doctor ever said that your blood pressure was too high or too low? Please specify ______ /_______
3. **YES** **NO** Are your ankles or feet often swollen?
4. **YES** **NO** Do you ever have spells of dizziness?
5. **YES** **NO** Do you have a history of high cholesterol?
6. **YES** **NO** Has your body weight changed more than 10 pounds in the last year?
7. **YES** **NO** Are you on a special diet? Please specify______________________________
8. **YES** **NO** Are you pregnant? (Women only)
9. **YES** **NO** Have you fallen in the last 3 months?
10. **YES** **NO** Do you currently have wounds that will not heal?

How would you evaluate your health status over the past 6 months? **SAME** **BETTER** **WORSE**

How many hours of sleep do you get a night? ______________________________

ORTHOPEDIC AND OTHER HEALTH CONCERNS

Have you ever had muscle, bone or joint illness or injury (including the back) in the past? **YES** **NO**

If yes, please explain: ______________________________

____

Do you currently have any muscle, bone or joint problems that may affect your activity level? **YES** **NO**

Please explain any other health concerns or complications

____

____

Has a physician ever place any restrictions on your activities? **YES** **NO**

If yes, please explain: ______________________________

____

MEDICATIONS

Are you currently taking any medications? **YES** **NO**

Please list all medications

____

____

PERSONAL HABITS

YES **NO** Do you smoke at present? If yes, how much? ______________________________

YES **NO** Have you ever smoked? If yes, when did you quit? _________________________

YES **NO** Do you drink alcoholic beverages? If yes, how much? ______________________

YES **NO** Do you drink coffee, tea, or soda? Cups/glasses per day: ____________________

Approximately how many 8 oz. glasses of water do you drink per day? ___________________________

EXERCISE

Do you currently engage in any form of regular exercise? **YES** **NO** If yes, please specify:

____

Have you ever participated in a regular exercise program? **YES** **NO** If yes, please specify:

____

How much physical exertion is required in your occupation? Please specify:

____

What is your primary reason for starting an exercise program?

____

Please list at least three goals you wish to achieve through your personal fitness program

____

____

____

What types of activities do you enjoy?

____

Are there any other comments or concerns that you may have?

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