In order to better assess your needs, please fill out this form completely and accurately. This information is essential to developing a program that safely and effectively addresses your goals. All information will be kept confidential.

Name: ______________________ Date of Birth: __/__/__ Age: ______
Address: ____
Street City State Zip Code
Phone: _____________ (h)________________(c)__________________ (w)
Best Time of Day to call: _________________
Email Address: _________________________

Occupation:
Employer: ________________________ Position: ___________________

Primary Health Care Provider:
Physician's Name: _____________________ Phone: _______________
Address: ____
Street City State Zip Code

Secondary Health Care Provider(s): please list the name and reason for seeing this provider (ob-gyn, psychiatrist, massage therapist, etc.)
Name: _________________________ Care Provided: ________________
Name: _________________________ Care Provided: ________________
Name: _________________________ Care Provided: ________________

Current Height: _________ Current Weight: ____________

Emergency Contact Information:
Name: ________________________ Phone: _______________________

What are your reasons for participating in a Fitness Program? Please be as specific as you can.

____
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____
____
____

Par Q – Please mark YES or NO to the following:

	YES	NO
Has your doctor ever said that you have a heart condition and recommended only medically supervised physical activity?		
Do you frequently have pains in your chest when you perform physical activity?		
Have you had chest pain when you were not doing physical activity?		
Do you lose your balance due to dizziness or do you ever lose consciousness?		
Do you have a bone, joint, or any other health problem that causes you pain or limitations that must be addressed when developing an exercise program (i.e.: diabetes, osteoporosis, high blood pressure, high cholesterol, arthritis, anorexia, bulimia, anemia, epilepsy, respiratory ailments, back problems, etc.)?		
Are you pregnant now or have given birth within the last 6 months?		
Have you had a recent surgery?		
Do you currently have mercury dental fillings (amalgams)?		

If you marked YES to any of the previous questions, please elaborate below:

____

____

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____

Please list any medications or supplements you are currently taking and what you take them for.

____

____

____

____

When was the last time you took antibiotics?

____

____

Fitness History:

1. Please describe your current exercise activity (frequency and duration):

____

____

____

2. What has prevented you from exercising in the past?

____

3. How many times per week and for what duration would you like to exercise?

____

4. Please describe your ideal training week: (include activity/specific days/time spent/days off/alone or with others, etc.) Be specific.

____
____
____
____

Lifestyle Questions:

1. Do you smoke? If yes, how much? ______________________________

2. How much water do you drink in a day? __________________________

3. Do you drink soda, diet soda or use artificial sweeteners? ________________________

4. How many times have you had a cold in the last year? __________________________

5. How often do you experience headaches/migraines? ___________________________

6. Please describe your typical sleep patterns. ________________________

7. On a scale of 1 – 10, how is your stress level? (1=very low, 10=very high) _________

8. What are your 3 biggest sources of stress?

____
____
____

9. Do you feel that you would benefit from help with your nutrition? Explain.

____
____

10. Do you obtain a yearly physical from your doctor? _________________