New Client Health Information
All information provided in these forms will be kept strictly confidential.

Name: _____ Age: _____ Today's Date: _____

Phone: _____ (May I text you?) Y/N Email: _____

Mailing Address: _____City_____State___ZIP_____

Goals: What is the most important priority for your health and wellness?

What is the next most important priority?

What activities do you LOVE to do? (even if you're not doing them right now)

Lifestyle Choices: How many days per week are you physically active? Please tell me what you do.

Please rate your ability for the following on a scale of 1-10 (10 is perfect).

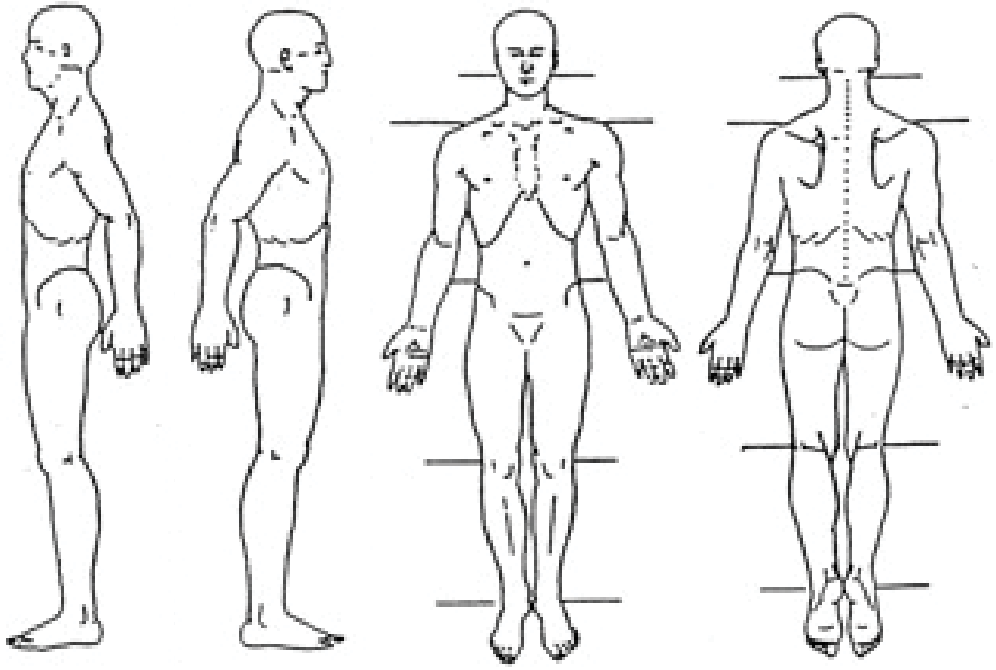
Fall asleep
Stay asleep/Fall back asleep if you wake up in the night
Manage stress
Positive Self-Talk (What you say to yourself in your head)
Digest food easily (without cramps, constipation or diarrhea)
Consume real, whole, pure foods on a daily basis
Hydrate enough that urine is pale yellow
Keep all organs and systems functioning at optimal health
Request help from my support system
Have enough energy to do what matters

What strategies do you use to manage stress?

What else would you like me to know about you, your habits, your life and your world?

Please mark location of any discomfort on the images below. Consider discomfort level this week, give each location a number from 1-10. Use the symbols in the key below.

Key: **P - Pain** **S - Stiffness** **N - Numbness**



Previous Injuries: _____

Previous Surgeries: _____

For areas that you want to address now, have you received medical diagnosis and from whom?

_____

What caused your discomfort? Include any specific event or stress related event.

_____

What movements or situations trigger the pain?

_____

Specifically, what has helped you so far?

_____

Updated 10/19/16

Physical Activity Readiness Questionnaire (PAR Q)

YES or NO

1. Has your doctor ever said that you have a heart condition and that you should only do physical activity recommended by a doctor?

2. Do you feel pain in your chest when you do physical activity?

3. In the past month, have you had chest pain when you were not doing physical activity?

4. Do you lose your balance because of dizziness or do you ever lose consciousness?

5. Do you have a bone or joint problem that could be made worse by a change in your physical activity?

6. Is your doctor currently prescribing drugs for your blood pressure or heart condition?

7. Do you know of any other reason why you should not do physical activity?

PAR Q: Adapted form ACSM's Health/Fitness Facility Standards and Guidleines, 1997 by American College of Sports Medicine

List all medications and the reasons you take them:

Updated 10/19/16

Waiver & Policies

By signing this document, I acknowledge that I have been informed of the need to obtain a physician's examination and approval prior to beginning this exercise and wellness program. I fully understand that the program may be strenuous and choose to participate completely voluntarily. I accept all responsibility for my health and any resultant injury or mishap that may affect my wellbeing, or health in any way. I hold harmless of any responsibility, the instructor, facility or any persons involved with this program or testing procedures.

Disclaimer: A fitness professional is not a medical doctor. Any chart or questionnaire does not replace the need for a medical exam and should not be used to defer seeking advice from a trained medical professional.

Waiver: I grant my fitness professional permission to consult with my primary care physician on my behalf and if needed I will contact medical professionals to allow communication related to my wellness program.

Cancellation Policy: I understand that if I do not show up for my appointment, or if I cancel within 24 hours, I will be charged 100% of the fee.

_____
Print Client Name

_____ _____
Signature Date

_____ _____
Signature of Adult if Client is under 18yrs of age Date