Client Information

Name:		Date:	
Address:		City:	State: / Zip Code:
Phone:	Cell:		
Date of Birth:	Age:	Height:	Weight:
E-Mail Address:		Referred by:	
Emergency Contact:		Relationship:	
Phone:	Cell:		

PERSONAL INFORMATION:

YES NO

☐ ☐ Are you currently under a doctor's care? (Other than yearly exam).

☐ ☐ If yes, explain:

☐ ☐ Does your doctor know you are participating in an exercise program?

☐ ☐ Advice from a doctor not to exercise, or to limit exercise?

☐ ☐ If yes, explain:

☐ ☐ Do you take any medications on a regular basis? (If you are currently on more than three medications please provide a detailed list on last page of this form)

1. Name:	Reason:	Year started:
1. Name:	Reason:	Year started:
1. Name:	Reason:	Year started:

☐ ☐ Are you taking any vitamins, minerals, supplements, or diet pills? If yes, provide information:

1. Name:	Reason:	Year started:
2. Name:	Reason:	Year started:
13 Name:	Reason:	Year started:

☐ ☐ Do you currently smoke cigarettes? If yes, how long?

☐ ☐ Are you currently pregnant or think you might be pregnant? If so, a medical release form from your doctor is required to your initial exercise session.

PERSONAL INFORMATION:

NAME:

Please check below if you have had the following and provide the year of occurrence or diagnosed in the space provided.

☐	Year:	Restrictions/Comments:
☐ Heart attack		
☐ Stroke		
☐ Seizures		
☐ Mitral Valve Prolapse		
☐ Diabetes		
☐ High Blood Pressure		
☐ High Cholesterol		
☐ Osteopenia/ Osteoporosis		
☐ Asthma		
☐ Rheumatoid Arthritis		
☐ Other		

ORTHOPEDIC INFORMATION:

Please check below if you have been DIAGNOSED with an injury or have had surgery on any of the following body parts. If YES, please give the year and explain in detail in the space provided:

RT	LT	BOTH		
☐	☐	☐	Head/Neck	
☐	☐	☐	Shoulder/ Clavicle	
☐	☐	☐	Back	
☐	☐	☐	Arm/Elbow	
☐	☐	☐	Wrist/Hand	
☐	☐	☐	Hip	
☐	☐	☐	Knee	
☐	☐	☐	Legs	
☐	☐	☐	Ankle	
☐	☐	☐	Foot	

Other Injuries/Surgeries:

1. Surgery:		Date:	
2. Surgery:		Date:	
3. Surgery:		Date:	

LEVEL OF PHYSICAL ACTIVITY: NAME:

When you are physically active, do you experience any of the following?
Please indicate Yes or No:

YES	NO	
☐	☐	Chest pain with exertion?
☐	☐	Lightheadedness or fainting?
☐	☐	Unusual shortness of breath?
☐	☐	Any difficulty with physical exercise?
☐	☐	Do you currently perform stretching and/or cardio exercise on a regular basis? (Outside of Fitness Cove)

EXERCISE:	FREQUENCY:

Which best describes your level of physical activity?

☐ Very Active ☐ Active ☐ Moderately Active ☐ Sedentary

Is there any reason, that has not already been addressed, that may warrant your avoidance of physical exertion? If so, please explain:

If there are any changes in your status relative to the above questions, please bring this information to the immediate attention of your fitness professional.

By signing below, you agree that all the above information you've provided is true to the best of your knowledge.

Signature: Date:
Signature: Date:
Signature: Date:
Signature: Date:

List of medications **CONTINUED**...

Name:		Reason:		Year started:	
Name:		Reason:		Year started:	
Name:		Reason:		Year started:	
Name:		Reason:		Year started:	
Name:		Reason:		Year started:	
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Name:		Reason:		Year started:	