GGS Client Intake Form

This questionnaire is designed to help me learn what I need to know to help you stay safe and healthy while reaching your goals. Please take your time to fill out this questionnaire as honestly as possible.

About You

Name:	**Email:**
Address:	**Date of birth:**
Phone Number:	**Gender pronouns:**
What's the best way to contact you? ☐ Call ☐ Text ☐ Email ☐ Other: _____	
Emergency Contact Name:	**Relationship:**
Emergency Contact Phone Number:	

Your Care Team

Primary Care Provider (PCP) Name:
PCP Phone Number/Email Address:
Permission to Contact PCP if Needed: ☐ Yes ☐ No

If you have an additional care provider you work with on a regular basis who you would like me to consult with (e.g., physiotherapist), please fill in their details below.

Care Provider Name:
Care Provider Phone Number/Email Address:
Permission to Contact Care Provider if Needed: ☐ Yes ☐ No

Please check the box that applies to you below:

- ☐ 1. I filled out the PAR-Q+, answered NO to all the questions, and am cleared for physical activity.
- ☐ 2. I filled out the PAR-Q+ and answered YES to one or more questions. My healthcare provider is aware of these conditions, and they have cleared me for exercise with no restrictions.
- ☐ 3. I filled out the PAR-Q+ and answered YES to one or more questions. My healthcare provider is aware of these conditions, and they have cleared me for exercise with restrictions or modifications.
- ☐ 4. I filled out the PAR-Q+ and answered YES to one or more questions. I have NOT been cleared by my healthcare provider for exercise.

If you checked box 1, 2, or 3, please sign the release below and provide a copy of your PAR-Q+ and any relevant medical instructions from your healthcare provider.

If you checked box 4, please get clearance from your healthcare provider before starting an exercise program. Ask them to provide any relevant limitations or guidelines for your program. Then, return this form along with their instructions to me. *If you choose to forgo medical clearance and start an exercise program, then by signing below, you are indicating that you understand and agree that you are exercising at your own risk and I, as your coach, cannot be held responsible for any injury, illness, or other harm that comes as a result of forgoing medical consultation. You also understand that I, as your coach, may not have the full scope of information I need to adequately tailor your program to your unique needs.*

Disclaimer and Release

→ I, the undersigned, have read, understood to my full satisfaction, and completed this questionnaire.

→ I understand that if my health changes, I must inform my coach and check with my primary healthcare provider that I'm still cleared for exercise.

→ I recognize that it is my responsibility to work directly with my primary healthcare provider before, during, and after seeking fitness and/or nutrition consultation.

→ I understand that any information provided is not to be followed without prior approval of my primary healthcare provider. If I choose to use this information without such approval, I agree to accept full responsibility for my decision.

→ I understand that fitness and/or nutrition coaching is undertaken at my own risk.

→ I understand that my coach may retain a copy of this form for their records. In these instances, they will maintain the confidentiality of the same, complying with applicable law.

Signature:	**Date:**

Setting Boundaries

Throughout our coaching partnership, there may be things that come up that you are or are not comfortable talking about. Topics such as your pelvic floor health, nutrition, sleep, and stress may all have an impact on your training and your results to varying degrees.

Please indicate which topics you are comfortable talking about with me by checking the relevant boxes (or checking the first box if you are comfortable talking about all of them). If you are not comfortable talking about a certain issue with me, leave the box(es) blank. You may change your decision at any time.

As you go through the rest of this form, feel free to leave any questions you don't feel comfortable answering blank.

☐ I am comfortable talking about all of the topics listed below.

I am only comfortable talking about these specific topics:

- ☐ Menopause
- ☐ Menstrual cycle
- ☐ Pelvic floor health
- ☐ Incontinence
- ☐ Pelvic organ prolapse
- ☐ Genitourinary syndrome of menopause
- ☐ Hot flushes and night sweats
- ☐ Digestive issues
- ☐ Sexual health
- ☐ Bone health
- ☐ Brain health, cognition, and mood
- ☐ Heart health
- ☐ Breast tenderness or related conditions
- ☐ Sleep
- ☐ Stress
- ☐ Emotional issues and mental health
- ☐ Body image
- ☐ Nutrition
- ☐ Weight and body composition
- ☐ Other: _____

There may also be instances where it can be helpful for me to manually cue or manually assess you, which requires physical touch.

Please indicate which body parts you are comfortable having me manually cue or assess by checking the relevant boxes (or checking the first box if you are comfortable having me manually cue or assess all of them). If you are not comfortable having certain areas (or any part of your body) touched for cueing or assessment, leave the box(es) blank. You may change your decision at any time.

In addition to your consent here, I will also obtain your verbal consent before manually cueing or assessing you during a training session.

☐ I am comfortable with my coach manually cueing and manually assessing all the body parts listed below.

I am only comfortable with my coach manually cueing and manually assessing these specific body parts:

- ☐ Feet
- ☐ Legs
- ☐ Hands
- ☐ Arms
- ☐ Head
- ☐ Glutes
- ☐ Abdomen (e.g., diastasis recti assessment)
- ☐ Upper back
- ☐ Lower back
- ☐ Neck
- ☐ Other: _____

Your Health Details

Please answer the following questions to the best of your knowledge.

Are you currently experiencing or have you recently experienced any muscle or joint pain?
☐ Yes ☐ No ☐ Unknown

If you answered yes, please explain:

Do you have a previous history of injury, pain, or physical limitations with any body parts?
☐ Yes ☐ No ☐ Unknown

If you answered yes, please explain:

Have you ever had surgery? ☐ Yes ☐ No ☐ Unknown

If you answered yes, please explain:

Have you ever had a bone density scan (DEXA scan)? ☐ Yes ☐ No ☐ Unknown

If so, what was your T-score? _____

Have you been diagnosed with osteopenia or osteoporosis? ☐ Yes ☐ No ☐ Unknown

If you answered yes, please explain and outline any guidance or instructions provided by your doctor:

Do you currently or have you ever experienced any of the following? If so, please check the boxes and provide relevant details in the space provided below.

MUSCULOSKELETAL

- ☐ Pain in the central pubic area
- ☐ Coccyx (tailbone) damage or pain
- ☐ Lower back pain
- ☐ Upper back pain
- ☐ Pins and needles – location: _____
- ☐ Shooting or radiating pain in back, glutes, or legs – location: _____
- ☐ Abdominal bulging or doming during exercise
- ☐ Neck pain
- ☐ Knee pain
- ☐ Any other joint pain (e.g., wrist) – please specify: _____
- ☐ Other (please specify): _____

PELVIC HEALTH

- ☐ Heaviness, dragging, or bulging in the pelvic area
- ☐ Pain in the pelvic area
- ☐ Diagnosis of pelvic organ prolapse
- ☐ Difficulty or discomfort with passing urine
- ☐ Uncontrollable gas
- ☐ Leaking of feces
- ☐ Straining during bowel movements (constipation)
- ☐ Leaking urine while coughing, sneezing, exercising, or exerting yourself
- ☐ Strong and sudden urge to urinate
- ☐ Leaking of urine at rest
- ☐ Pain in the perineum during sexual intercourse (or any other time)
- ☐ Unexplained bleeding during or after exercise

OTHER

- ☐ Hemorrhoids
- ☐ Varicose veins
- ☐ Constipation
- ☐ Acid reflux
- ☐ History of blood clots
- ☐ Type 1 diabetes
- ☐ Type 2 diabetes
- ☐ Low blood pressure
- ☐ High blood pressure
- ☐ Respiratory disease
- ☐ Other (please specify): _____

Use this space to provide details on any boxes checked above. Please include when symptoms started/diagnosis happened, any treatment(s), and current status.

Have you been diagnosed (currently or in the past) with any significant medical conditions and/or injuries that you haven't mentioned yet? ☐ Yes ☐ No ☐ Unknown

If you answered yes, please check all that apply and explain:

- ☐ Heart condition
- ☐ Asthma
- ☐ Cancer
- ☐ Type 1 diabetes
- ☐ Type 2 diabetes
- ☐ Autoimmune condition
- ☐ Thyroid disease
- ☐ Seizures
- ☐ Fibromyalgia
- ☐ Arthritis
- ☐ Blood disorder
- ☐ Osteoporosis
- ☐ Knee pain or injury
- ☐ Neck pain or injury
- ☐ Back pain or injury
- ☐ Other (please list): _____ _____ _____

Use the space below to provide details on any boxes checked above.

Are you taking any medications, either over-the-counter or prescription?

☐ Yes ☐ No ☐ Unknown

If you answered yes, please provide medication and dosage information:

☐ _____ ☐ _____

☐ _____ ☐ _____

☐ _____ ☐ _____

☐ _____ ☐ _____

☐ _____ ☐ _____

Have you ever experienced any other major medical event you want me to know about?

☐ Yes ☐ No ☐ Unknown

If you answered yes, please explain what happened, and when:

Have you met with any of the following healthcare professionals in the past 12 months?

☐ Physiotherapists ☐ Chiropractors

☐ Acupuncturists ☐ Other (please specify): _____

Please describe the reason(s) for your visit(s):

Women's Health

Do you menstruate? ☐ Yes ☐ No ☐ Unknown

If so, are your cycles regular (within ~7 days)? ☐ Yes ☐ No ☐ Unknown

If you'd like to expand, you can do so here:

Are you in perimenopause? ☐ Yes ☐ No ☐ Unknown

Has your menopause been confirmed? (i.e., you've gone 365 without a menstrual cycle)
☐ Yes ☐ No ☐ Unknown

If so, when? _____

Are you currently taking or have you previously taken menopause hormone therapy?
☐ Yes ☐ No ☐ Unknown

If you answered yes, please explain:

Are you experiencing any of the following symptoms?

- ☐ Hot flushes
- ☐ Night sweats
- ☐ Cognitive changes (e.g., brain fog, memory issues, difficulty concentrating)
- ☐ Mood changes (e.g., anxiety, anger)
- ☐ Sleep disruptions or insomnia
- ☐ Migraines or headaches
- ☐ New aches and pains
- ☐ New food sensitivities
- ☐ New gastrointestinal symptoms (e.g., acid reflux)
- ☐ Weight gain or body composition changes
- ☐ Incontinence
- ☐ Breast changes or sensitivity
- ☐ Other (please list): _____

Your Past Birth Experience(s)

Please fill out this section if you've experienced birth in the past. If you haven't, skip down to "Your Training."

Date(s) of birth: _____

Birth type: ☐ Vaginal ☐ Assisted ☐ C-section

Tearing: ☐ Yes ☐ No If yes, degree of tearing (if known): _____

Other complications, if any: _____

Is there anything else you want me to know about your past birth experience(s)?

Your Training

In general, what are your goals for training? Check all that apply.

- ☐ Gain strength
- ☐ Gain muscle
- ☐ Gain bone density
- ☐ Improve mobility
- ☐ Improve balance
- ☐ Improve aerobic fitness
- ☐ Improve pelvic floor function
- ☐ Improve overall health
- ☐ Improve mental health
- ☐ Improve or mitigate menopause symptoms
- ☐ Lose weight
- ☐ Gain weight
- ☐ Feel more in control
- ☐ Reduce risk of falling
- ☐ Reduce aches and pains
- ☐ Have fun
- ☐ Compete in an event _____
- ☐ Other: _____

Out of the goals you checked, which ones feel most important? Please rank your top 3.

1. _____
2. _____
3. _____

How many times per week do you currently exercise? What types of exercise do you do?

Are you happy with the frequency of your exercise routine at the moment? How much time can you devote to your training each week?

How's your exercise routine working for you right now? What, if anything, do you want to change or add?

What types of training have you done in the past five years, if any? Did it help you achieve the results you were looking for?

Your Lifestyle

The purpose of the following questions is to help me, as your coach, get a better understanding of your lifestyle. Sleep, nutrition, hydration, and stress all affect your training and recovery.

When I have a better understanding of these factors, I can modify your workouts accordingly to ensure you can recover. It also helps us work together to make sure your program leaves you feeling strong and energized.

STRESS AND RECOVERY

How much sleep do you get in a 24-hour period? _____

Rate your general stress level on a scale of 1–10 (1=little, 10=extreme): _____

Do you feel depressed or anxious? ☐ Yes ☐ No

Do you suffer from mood swings? ☐ Yes ☐ No

Have you ever been diagnosed with depression or anxiety? ☐ Yes ☐ No

If you'd like to expand on any of these questions, you can do so here:

NUTRITION

How much water do you drink in a 24-hour period? _____

Who does most of the grocery shopping & cooking in your household? _____

What does your nutrition look like on a "typical" day? Please list meals, snacks, and beverages.

What, if any, nutrition challenges do you struggle with? (For instance, do certain foods cause acid reflux? Do you struggle to eat veggies on a regular basis?)

What, if any, changes would you like to make to how you're eating, and why?

Your Environment

Who do you live with? (e.g., spouse/partner, parents, roommates, pets, children)

What, if any, major obstacles are you encountering at home or with loved ones when it comes to your efforts to train, eat, and recover?

Your Interests

How do you spend your time / what do you do for work?

What are your favorite hobbies (if you have any)?

What is your favorite thing about yourself (physical, mental, personality, etc.)?

What do you believe are your biggest strengths?

What fills you up and brings you joy?

Your Coaching

What drove you to seek out coaching with me?

What do you hope to get out of our coaching experience?

What do you expect from me as your coach?

Is there anything else you want to share that you haven't been asked yet?