Name: Age: Today’s Date:

Date of Birth: How did you hear about us?

What activities would you like to do?

|  |  |  |
| --- | --- | --- |
| **What are your physical limitations?** | **Date started/diagnosed?** | **What makes limitation worse?** |
| 1. |  |  |
| 2. |  |  |
| 3. |  |  |

**List Current Medical Conditions**

|  |
| --- |
| Eyes |
| Ear, Nose, Throat  |
| Cardiovascular  |
| Respiratory  |
| Gastrointestinal  |
| Joints  |
| Skin  |
| Neurological  |
| Psychiatric  |
| Endocrine |

**Notes**

Flexibility:

Cardio Endurance:

Muscular Strength:

Balance:

**Signature: Date:**