Client Intake Form

Name: _____ DOB: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home phone: _____ Cell Phone: _____

Email address_____

Occupation: _____

Emergency Contact Name: _____ Relationship: _____

Contact Phone Number(s): _____

How did you hear about us? _____

Health History

How would you describe your present state of health? (Very healthy, Healthy, Unhealthy, Very unhealthy, Other)

_____

Do you now or have you in the past had:

1. History of heart problems, chest pain, or stroke _____
2. Increased blood pressure _____
3. High Cholesterol _____
4. Recent surgery (past 12 months) _____
5. History of breathing or lung problems _____
6. Muscle, joint, or back disorder or any previous injury still affecting you _____

7. Diabetes or thyroid condition _____
8. Hernia or any condition that may be aggravated by lifting weights _____
9. Any chronic illness or condition (osteoporosis, arthritis, cancer) _____
10. Are you taking any medications or drugs? _____
11. Do you suffer from dizziness or loss of consciousness? _____
12. Do you know of any reason why you should not exercise? _____

If you answered yes to any of the above questions, please explain below:

_____
_____
_____

Physical Activity

Please describe your fitness history.

_____
_____
_____

Are you presently involved in any type of fitness program? If yes, what types of activities are you involved in, how long of a period, and how many times a week?

_____
_____
_____

Have you ever experienced any injuries that may limit your physical activity? Please describe.

_____
_____
_____

Do you have any physical activity restrictions?

_____
_____
_____

What are your honest feelings about exercise/physical activity?

_____
_____
_____

What are some of your favorite physical activities?

_____
_____
_____

What are your leisure activities?

_____
_____
_____

How much time are you willing to devote to an exercise program? _____ minutes/day _____ days/week

How long have you been regularly exercising? _____ months _____ years

What are your health and fitness goals?

_____
_____
_____

Nutrition

What are your dietary goals?_____

Have you ever followed a modified diet?_____

Are you currently following a specialized eating plan?_____

If yes, why did you choose this eating plan?_____

Have you ever met with a registered dietician or attended nutrition classes?_____

What do you consider to be the major issues with your nutritional or eating plan (eating late at night, snacking on high fat foods, skipping meals, lack of variety, etc.)

_____
_____
_____

How many ounces of water do you drink a day?

_____

What do you drink other than water?

_____

Do you have any food allergies or intolerances?

_____

Who shops for and prepares your food? _____

_____

How often do you dine out?_____

Sleep and Stress

How many hours do you sleep at night?_____

Rate your average stress level from 1 (no stress) to 10 (constant stress)._____

What is most stressful for you?_____

How is your appetite affected by stress? Please circle.

Increased Not affected Decreased

What would you like to do with your weight? Please circle.

Lose weight Maintain weight Gain weight

What was your lowest weight within the past 5 years?_____

What was your highest weight within the past 5 years? _____

What do you consider to be your ideal weight (the sustainable weight at which you feel best)? It's okay if you don't know._____

Would you like to know your current body fat percent and skeletal muscle percent? We can do that in office.

Yes No

Goals

On a scale of 1 to 10, how ready are you to adapt a healthy lifestyle (1=very unlikely, 10=very likely)?

_____

Do you have any specific goals for improving your health? If so, please describe. Also, describe why you want to achieve these goals.

_____
_____
_____
_____
_____

Readiness to Change Questionnaire

Please answer yes or no to the following questions.

1. Are you looking to change a specific behavior? _____

2. Are you willing to make this behavior change a top priority? _____

3. Have you tried to change this behavior before? _____

4. Do you believe there are inherent risks/dangers associated with not making this behavioral change? _____

5. Are you committed to making this change, even though it may prove challenging? _____

6. Do you have support for making this change from friends, family, and loved ones? _____

7. Are you prepared to be patient with yourself if you encounter obstacles, barriers, and/or setbacks? _____