



## **EXERCISE PHYSIOLOGY INITIAL CONSULTATION**

### Patient information

Name:

Date of Birth:

Address:

Phone:

Email:

Emergency contact (name, relationship and number):

Referring physician (if applicable):

Injuries/surgeries (including joint replacements)	Medications & dosages	Allergies

Past medical history	Current medical conditions

Family history health and conditions \_\_\_\_\_

(relevant to exercise) \_\_\_\_\_

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### **EXERCISE HISTORY**

Current exercise routine	Exercise goals	Previous experience exercise

**SMOKING HISTORY/USE:** \_\_\_\_\_

**ALCOHOL HISTORY/USE:** \_\_\_\_\_





## OTHER LIFESTYLE FACTORS

<b>Sleep Patterns</b>	
<b>Dietary Habits:</b>	
<b>Occupation:</b>	

<b>Types of goals</b>	<b>What I want</b>
Habit changes	
Changes in short term	
Changes in long term	

<b>Nutrition concerns (if applicable)</b>	<b>Hydration concerns (if applicable)</b>

<b>What will you sacrifice to improve your health and lifestyle? If you are serious, then why?</b>	
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### Client Acknowledgment:

I have reviewed and understand the information provided during this initial consultation. I acknowledge that the exercise program and recommendations are based on the information I have provided about my medical history, goals, and expectations. Cancellation Policy: I agree that failure to provide notice of cancellation within 24 hours of an appointment (regardless of reason) will result in a 100% cancellation fee.

### Client Signature:

Date:

Exercise Physiologists Signature & Date:

