



GENERAL INTAKE INFORMATION

(Answer Each Question By Printing The Necessary Information. Your Information is Strictly Confidential.)Thank You!

Name _____ *Date* _____

Date of Birth _____ *Age* _____

Address _____

City, State, Zip _____

Home Phone _____ *Cell Phone* _____

Work Phone _____ *Fax* _____

Email Address _____

Employer _____ *Occupation* _____

*In case of **EMERGENCY**, please notify* _____

Name _____ *Relationship* _____

Address _____

City, State, Zip _____

Home Phone _____ *Cell Phone* _____

Work Phone _____

MEDICAL INFORMATION

Name of Physician _____

Phone _____

Are you under the care of a physician, chiropractor, or other health care professional for any reason? Yes _____ No _____

If yes, List reason _____

Are you currently taking any medications on a permanent or semi permanent basis?

Yes _____ No _____

Type	Dosage/Frequency	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____

Has your doctor ever said your blood pressure is to high? _____

Has your doctor ever told you that you have a bone or joint problem that has been or could be made worse by exercise? _____

I rate my current fitness level as a (1-10), ten being high. _____

Are you unaccustomed to vigorous exercise? _____

Is this the first time working with a Certified Personal Fitness Trainer? _____

Is there any reason not mentioned why you should not follow a regular exercise program? _____

Have you recently experienced chest pain associated with either exercise or stress?

Do you currently or have previously smoked cigarettes? _____

Packs per day? _____

Are you allergic to any medication (aspirin, penicillin, sulfa, etc.)? _____

PERSONAL AND FAMILY MEDICAL HISTORY

If there is a personal history for any condition please check P and list any medication taken for that condition. If there is a family history of any condition please check F and list the relation to you.

Asthma: P _____ *List Medications taken* _____

F _____ *Relation to you* _____

*Respiratory/
Pulmonary*

Conditions: P _____ *List Medications taken* _____

F _____ *Relation to you* _____

Diabetes:

Type I P _____ *List Medications taken* _____

F _____ *Relation to you* _____

Type II P _____ *List Medications taken* _____

F _____ *Relation to you* _____

*Hypo-
glycemia:*

Lower than normal levels of glucose (sugar) in the blood.

P _____ *List Medications taken* _____

F _____ *Relation to you* _____

Hyper-glycemia:

Excessive amounts of glucose (sugar) in the blood.

P _____ *List Medications taken* _____

F _____ *Relation to you* _____

Hyper-lipidemia:

Abnormal levels of lipids in the blood..

P _____ *List Medications taken* _____

F _____ *Relation to you* _____

Epilepsy:

Chronic neurological disorder characterized by recurrent unprovoked seizures.

P _____ *List Medications taken* _____

F _____ *Relation to you* _____

Anemia:

Deficiency of hemoglobin inside the red blood cells. Caused by lack of iron in the body which leads to lack of oxygen in the organs.

P _____ *List Medications taken* _____

F _____ *Relation to you* _____

**High Blood Pressure/
Hypertension:**

P _____ *List Medications taken* _____

F _____ *Relation to you* _____

High Cholesterol:

P _____ *List Medications taken* _____

F _____ *Relation to you* _____

Heart Disease:

P _____ *List Medications taken* _____

F _____ *Relation to you* _____

Lung

Disease: P _____ *List Medications taken* _____

F _____ *Relation to you* _____

Kidney

Disease: P _____ *List Medications taken* _____

F _____ *Relation to you* _____

Liver

Disease: P _____ *List Medications taken* _____

F _____ *Relation to you* _____

Heart

Attack: P _____ *List Medications taken* _____

F _____ *Relation to you* _____

Stroke:

P _____ *List Medications taken* _____

F _____ *Relation to you* _____

Gout:

Metabolic Arthritis. Disease created by the build up of uric acid, causing inflammation & pain in the cartilage of joints and tendons.

P _____ *List Medications taken* _____

F _____ *Relation to you* _____

Angina:

Painful constriction or tightness somewhere in the body.

P _____ *List Medications taken* _____

F _____ *Relation to you* _____

**Gastro-
Intestinal
Disorder:**

Disease that pertains to the gastrointestinal tract. Esophagus, stomach, large intestines, colon, etc.

P _____ *List Medications taken* _____

F _____ *Relation to you* _____

**Thyroid
Disorder:**

P _____ *List Medications taken* _____

F _____ *Relation to you* _____

Osteoporosis: *Disease of the bone. Increase risk of fracture.*

P _____ *List Medications taken* _____

F _____ *Relation to you* _____

Scoliosis: *Side to side curvature of the spine.*

P _____ *List Medications taken* _____

F _____ *Relation to you* _____

**Akylosing
Spondylitis
(AS):**

Arthritis of the spine. Affects the spinal joints.

P _____ *List Medications taken* _____

F _____ *Relation to you* _____

**Spondylo-
listhesis:**

Displacement of the vertebra or vertebral column. Vertebra slips, generally in the lumbar spine.

P _____ *List Medications taken* _____

F _____ *Relation to you* _____

Sciatica:

Pain caused by compression or irritation of one of the five nerve roots that gives rise to the sciatic nerve. Pain in lower back, buttock, leg or foot.

P _____ *List Medications taken* _____

F _____ *Relation to you* _____

LIFESTYLE AND DIETARY FACTORS

Please fill in the information below:

Occupational Stress *Low* _____ *Med* _____ *High* _____

Personal Stress *Low* _____ *Med* _____ *High* _____

Energy Level *Low* _____ *Med* _____ *High* _____

Caffeine Intake
Daily _____

Alcohol Intake
Weekly _____

Colds Per Year _____

MUSCULOSKELETAL INFORMATION

Please describe any past or current musculoskeletal conditions you have incurred such as muscle pulls, sprains, fractures, broken bones, surgery, back pain, or general discomfort. Please indicate Left or Right sides of the body:

Head/Neck _____

Upper Back _____

Shoulder/Clavicle _____

Arm/Elbow _____

Wrist/Hand _____

Lower Back _____

Hip/Pelvis _____

Thigh/Knee _____

Arthritis _____

Hernia _____

Other _____

Have you ever been Knocked Out? Yes _____ No _____

Explain _____

Do you wear Glasses or Contact Lenses? Yes _____ No _____

Describe _____

Do you have children? Yes _____ No _____

Vaginal or Caesarian Births? _____

Birthing Complications? Yes _____ No _____

Explain _____

Are you currently trying to get pregnant? Yes _____ No _____

NUTRITIONAL INFORMATION

Are you on any specific food/diet plan at this time? Yes _____ No _____

Describe _____

Do you take Dietary Supplements? Yes _____ No _____

Describe _____

Do you experience any frequent weight fluctuations? Yes _____ No _____

Describe _____

How would you describe your current nutritional habits? _____

Sleep Patterns _____

OBJECTIVES AND GOALS

1. Short Term _____

2. Long Term _____

Commitment to Program:

1. How many Days per week to commit to working out? _____

2. Do you have any equipment at home? If so what type? _____

Are you training for a specific event? _____

Print Name _____

Signature _____

Date _____