CLIENT INFORMATION

Name: ____

Address: ____

Contact number: ____________________ Work number (if applicable): ____________________

Date of Birth (D/M/Y): _____/______/______ Occupation: ______________________________

Check any that apply:

- ☐ You are a male over the age of 45 *or* ☐ You are a female over the age 55
- ☐ You are physically active (Physical training 3x per week; at a minimum of 30 minutes)
- ☐ You presently smoke or have recently quit (within 6 months)
- ☐ You have high blood pressure and/or take medication for high blood pressure
- ☐ You have high cholesterol
- ☐ Have family history of heart disease, diabetes, stroke
- ☐ Immediate family has/does had/have a heart condition (55+ Male) (65+) Female

Exercise Habits

- ☐ Intensive Occupational / Recreational exertion
- ☐ Moderate Occupational / Recreational exertion
- ☐ Sedentary Occupation / Intense Recreational exertion
- ☐ Sedentary Occupation / Moderate Recreational Exertion
- ☐ Sedentary Occupation / Light Recreational Exertion
- ☐ Complete lack of Occupation/Recreation exertion

Any reason why you can’t exercise regularly?____

____

____

____

What are your favorite exercises?

1. ______________________________

2. ______________________________

3. ______________________________

Existing Medical Conditions

Check all that apply.

☐ Anemia	☐ Diabetes	☐ Obesity
☐ Arthritis	☐ Epilepsy	☐ Pregnancy
☐ Asthma	☐ Heart Condition	☐ Thyroid Problem
☐ Cholesterol	☐ Hernia	☐ Ulcer

☐ Other (please specify): ______________________________

____

Medications

Are you currently taking any kind of medication, prescription or otherwise? ☐ Yes ☐ No

If yes, then please list medications and what condition it is for.

Medication: ____________________ Condition: ____________________

Medication: ____________________ Condition: ____________________

Medication: ____________________ Condition: ____________________

Medication: ____________________ Condition: ____________________

Allergies

Do you have allergies? ☐ Yes ☐ No

If yes, please list allergies, and if they require medication.

Allergy: ____________________ Medication: ____________________

Allergy: ____________________ Medication: ____________________

Allergy: ____________________ Medication: ____________________

Injuries

Do you have any previous or current injuries? ☐ Yes ☐ No

If yes, please check where injury occurred (circle which side) and specify injury:

☐ Neck	☐ Shoulders R / L	☐ Upper back
☐ Lower Back	☐ Elbow R / L	☐ Wrist R / L
☐ Hip R / L	☐ Knee R / L	☐ Ankle R / L

☐ Other (please specify): ______________________________

____

Emergency Contact Information

Name: ______________________ Phone number: ______________

Relation: ______________________________

Family Physician

Name: ______________________ Phone number: ______________

City: ______________________________

Lifestyle

	Always	*Usually*	*Sometimes*	*Never*
I get 7-8 hours of sleep per night	☐	☐	☐	☐
I am physically active at least 3x per week	☐	☐	☐	☐
I have regular medical checkups	☐	☐	☐	☐
I get 2-3 servings of fruit daily	☐	☐	☐	☐
I eat 2-4 serving of veggies daily	☐	☐	☐	☐
I eat 6-10 servings of grain product daily	☐	☐	☐	☐
I eat 2-3 servings of meats and nuts daily	☐	☐	☐	☐
I am conscious about my nutritional habits	☐	☐	☐	☐

	Always	*Usually*	*Sometimes*	*Never*
I follow a strictly scheduled lifestyle	☐	☐	☐	☐
I feel grounded and have no stress in my life	☐	☐	☐	☐
I am a happy and positive person	☐	☐	☐	☐
I consciously express my emotions	☐	☐	☐	☐
I consciously express my creative side	☐	☐	☐	☐
I consciously express my spiritual side	☐	☐	☐	☐
I consciously empower myself with what I want	☐	☐	☐	☐
I verbally express what I want to others	☐	☐	☐	☐
I follow my intuition (gut instinct)	☐	☐	☐	☐
I listen to what my body is telling me	☐	☐	☐	☐
I have very good moral qualities	☐	☐	☐	☐

Signature(s)

Participant's signature Date

Print name

Parent or legal guardian *(if participant is under age eighteen)* Date

Print name