# Client Intake Form

Date: _____

Name: _____ Date of Birth: _____

Preferred Gender Pronoun: _____

**Contact Details**

Email address: _____

Telephone number: (home) _____ (mobile) _____

Emergency Contact: (name) _____ (phone) _____

How did you hear about us? _____

**It is important that you take a few minutes to answer the following questions, or work through them with your instructor. Please ensure that you complete ALL questions listed below. The information contained will be treated as confidential and will not be released or revealed to any third party sources without your consent.**

Why are you interested in moving? _____

What are your main priorities at this time? Check all that apply.

- ☐ Pain management/rehabilitation
- ☐ Enhanced strength and mobility
- ☐ Improved body awareness
- ☐ Enhanced understanding of body mechanics
- ☐ Improvement in other activities (day-to-day or exercise-oriented functional movement)
- ☐ Manage anxiety and self doubt
- ☐ Other: _____

What prevented you from starting earlier? Is this still an issue?

Have you achieved fitness and health goals in the past?

Do you see or feel any obstacles or challenges will get in the way of you achieving any of your goals?

How many days each week can you commit to training (in studio or at home) and for how long?

How do you prepare your food each week and are you prepared to make gradual and progressive nutritional changes to optimize results?

What do you do to recover, de-stress and unwind?

How do you perceive your overall health? What are your biggest concerns?

What do you do for a living and how do you get to work?

How would you rate your stress levels throughout the day?

How would you rate your energy levels throughout the day?

**Injury History (including surgeries)**

Have you ever been treated by a physician for (check all that apply):

- ☐ Arthritis
- ☐ Chronic Fatigue Syndrome
- ☐ Diabetes
- ☐ Fibromyalgia
- ☐ High blood pressure
- ☐ Gout
- ☐ Stroke
- ☐ Dizziness or Fainting, Vertigo
- ☐ Kidney or Liver Conditions
- ☐ Asthma
- ☐ Thyroid conditions
- ☐ Other (please specify):
- ☐ Low blood pressure
- ☐ Gastric Reflux
- ☐ Glaucoma
- ☐ Any heart condition
- ☐ Multiple Sclerosis
- ☐ Heart Murmur
- ☐ Epilepsy
- ☐ High Cholesterol/Triglycerides
- ☐ Rheumatic Fever
- ☐ IBS
- ☐ Cancer

Mood conditions:

☐ Depression
☐ Bipolar
☐ Anxiety
☐ Other (please specify):

Orthopedic/Joint Issues (shoulder, elbow, spine, hip, knee, ankle, wrist):

☐ ACL/PCL/MCL injuries
☐ Meniscal tear (whole or partial)
☐ Herniated or bulging disc
☐ Total hip replacement
☐ Osteoporosis/Osteopenia
☐ Peripheral Neuropathy (numbness, tingling)
☐ Spondylolithesis
☐ Facet joint syndrom
☐ Stenosis
☐ Knee replacement
☐ Osteoarthritis
☐ Rheumatoid Arthritis

Musculoskeletal/Neuromuscular issues:

☐ Adhesive capsulitis (frozen shoulder)
☐ Carpal Tunnel Syndrome
☐ Plantar Fasciitis
☐ Pelvic Floor Prolapse
☐ Other (please specify):
☐ Rotator cuff impingement
☐ Thoracic outlet syndrom
☐ Diastasis Recti
☐ Hernia

Prior Surgeries (please include date):

Are you pregnant? ☐ Y ☐ N ☐ N/A If yes, due date: _____

Prior deliveries: (month, year)

Current medications (dosage, frequency):

Current supplements (dosage, frequency):

Please list any other wellness providers you are currently received services/treatment from (chiropractor, physiotherapy, osteopathy, naturopath, etc.):

Are you currently or do you fast? ☐ Y ☐ N

How would you rate your digestion on a scale of 1-10, where 1 is constant irritation and 10 is none? _____

Do you experience any of the following? Select all that apply.

| | | |
|---|---|---|
| ☐ Constipation | ☐ Diarrhoea | ☐ Bloating |
| ☐ Gas | ☐ Acid Reflux | ☐ Heart burn |
| ☐ Food allergies | ☐ Cramping | |
| ☐ Other (please specify): | | |

How often do these issues occur? _____

How do you rate your sleep on a scale of 1-10 (where 10 is a great sleep)? _____

Do you ever experience any of the following:

| | | |
|---|---|---|
| ☐ Waking tired | ☐ Needing too much sleep | ☐ Too little sleep |
| ☐ Waking too early | ☐ Difficulty getting to sleep | ☐ Waking often at night |
| ☐ Wandering mind | ☐ Anxiety at night | ☐ Waking to pee |

Activity Level/Exercise Frequency (daily, 2-3 times per week, once a week, etc.):

sdfsdf

Prior movement experience (check all that apply):

| | | | |
|---|---|---|---|
| ☐ Yoga | ☐ Weight lifting | ☐ Feldenkrai | ☐ Swim |
| ☐ Pilates | ☐ Running | ☐ Alexander Technique | ☐ Crossfit |
| ☐ Dance | ☐ Cycling | ☐ Crossfit | |

☐ Other:

Any postural concerns?

If you selected any of the conditions or health concerns above, please take this form to your doctor and ask for clearance to exercise before starting any exercise program OR sign below if you have already cleared the above condition with your doctor. Please submit any additional information pertaining to major conditions and related medications in a separate form/medical history file. Any changes in your health/medication regime should be submitted to your instructor as soon as you're aware of them.

This document states the truth regarding specific details of my health. I recognize that the instructor is not able to provide me with medical advice in regards to my medical fitness and that this information is used as a guide to the limitations of my ability to exercise.

By signing below, you also acknowledge our 24-hour cancellation policy, whereby you will be charged a 100% fee for last minute cancelations.

Client's Signature: _____ Date: _____

Trainer's Signature: _____