# Client Intake Screen

**Name:** _____ **Date:** _____

**Address:** _____ **Phone:** (C) _____

**Email:** _____ **Phone:** (W) _____

**Emergency Contact:** _____ **Emergency #:** _____

**Physician Name:** _____ **Physician #:** _____

**Birthday:** _____ **Age:** _____

## Occupational

**Occupation:** _____

**Does your occupation require repetitive movements, extended periods of sitting, typing, or heavy lifting?**

Yes ☐ No ☐ **If yes, please explain:**

_____

## Lifestyle/Recreational

**How many hours of sleep do you typically get each night?** _____

**Do you partake in any recreational hobbies? (golf, skiing, reading, video games, etc)** Yes ☐ No ☐

_____

**How many days/week are you wanting in-person sessions?** ____ **Which days?(next line)** **Check here if it will vary** ☐

**Mon: AM** ☐ **PM** ☐ **Tues: AM** ☐ **PM** ☐ **Wed: AM** ☐ **PM** ☐ **Fri: AM** ☐ **PM** ☐

**Sat: AM** ☐ **PM** ☐ **Sun: AM** ☐ **PM** ☐

**How many days per week are you wanting to train on your own using the online app?** _____

**How often do you experience negative stress from each of the following?**

| | Always | Frequently | Usually | Rarely | Never |
|---|---|---|---|---|---|
| **Work:** | ☐ | ☐ | ☐ | ☐ | ☐ |
| **Home or family:** | ☐ | ☐ | ☐ | ☐ | ☐ |
| **Social Pressure:** | ☐ | ☐ | ☐ | ☐ | ☐ |
| **Personal Health:** | ☐ | ☐ | ☐ | ☐ | ☐ |

## Current Medical Information

**Have you ever had any injuries or surgeries? Please explain** Yes ☐ No ☐

_____

_____

**Do any of the following occur two or more times/month?**

| | | | | | |
|---|---|---|---|---|---|
| **Cough up blood** (MC) | ☐ | **Arm or shoulder pain** (MC) | ☐ | **Loss of breath w/ low exertion** (MC) | ☐ |
| **Abdominal pain** (MC) | ☐ | **Chest Pain** (RF) (MC) | ☐ | **Recent unexplained weight loss/gain** (MC) | ☐ |
| **Low-back pain** (MC) | ☐ | **Swollen/painful Joints** (MC) | ☐ | **Fever, nausea, unusual fatigue** (MC) | ☐ |
| **Leg pain** (MC) | ☐ | **Palpitation or fast heartbeat** (MC) | ☐ | **Numbness/tingling in any limbs** (MC) | ☐ |
| **Blood pressure over 140/90** | ☐ | ***Blood pressure over 160/100** | ☐ | ***Resting heart rate over 100bpm** | ☐ |

***Medical clearance will be required from your physician before starting an exercise program**

## Medical History

**Have you been diagnosed/treated for any of the following:**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Alcoholism** (SEP) | ☐ | **Diabetes** (SEP) | ☐ | **Mental Illness** (SEP) | ☐ | | |
| **Anemia** (SEP) | ☐ | **Emphysema** (SEP) | ☐ | **Neck Strain** (SLA) | ☐ | | |
| **Asthma** (SEP) | ☐ | **Epilepsy** (SEP) | ☐ | **Obesity** (RF) | ☐ | | |
| **Back Strain** (SLA) | ☐ | **Eye problems** (SLA) | ☐ | **Phlebitis** (MC) | ☐ | | |
| **Bleeding Trait** (SEP) | ☐ | **Gout** (SLA) | ☐ | **Rheumatoid arthritis** (SLA) | ☐ | | |
| **Bronchitis, chronic** (SEP) | ☐ | **Hearing loss** (SLA) | ☐ | **Stress/Anxiety** (RF) | ☐ | | |
| **Stroke** (MC) | ☐ | **Heart problems** (MC) | ☐ | **High blood pressure** (MC) | ☐ | | |
| **Thyroid Problem** (SEP) | ☐ | **Cancer** (SEP) | ☐ | **HIV** (SEP) | ☐ | | |
| **Ulcer** (SEP) | ☐ | **Cirrhosis** (MC) | ☐ | **Hypoglycemia** (SEP) | ☐ | | |
| **Congenital defect** (SEP) | ☐ | **Hyperlipidemia** (RF) | ☐ | Other | ☐ | | |
| **Concussion** (MC) | ☐ | **Kidney problems** (MC) | ☐ | Other | ☐ | | |

**List anything not included on this questionnaire that may cause you problems in a fitness program:**

_____

_____

## Goals

**Please rate on a scale of 1-10 how important each of these goals are to you:**

| | | |
|---|---|---|
| **Cardiovascular:** | **Increase Strength:** | **Build Muscle:** |
| **Lose Body Fat:** | **Increase Energy:** | **Improve Flexibility:** |
| **Improve Balance:** | **Improve Coordination:** | |

**What is your training history?**

_____

_____

_____

**Do you own any exercise equipment? If so, please list what you have.**

_____

_____

**Have you every had any bad experiences with an exercise program/trainer? If yes, please explain.**

_____

_____

**Have you ever started exercise programs but then find yourself unable to stick to them? If yes, please explain the barriers.**

_____

_____

## Upper Extremity Functional Index

Do you have difficulty performing any of the following activities in regards to your upper body?

| | Extreme Difficulty/ Unable to Perform | Quite a Bit of Difficulty | Moderate Difficulty | A Little Bit of Difficulty | No Difficulty |
|---|---|---|---|---|---|
| Any usual housework: cleaning, vacuuming, laundry, standing at kitchen counter cooking | 0 | 1 | 2 | 3 | 4 |
| Lifting a bag of groceries or suitcase from the floor to waist level | 0 | 1 | 2 | 3 | 4 |
| Getting into or out of the bathtub | 0 | 1 | 2 | 3 | 4 |
| Putting objects, or removing from overhead shelves | 0 | 1 | 2 | 3 | 4 |
| Driving | 0 | 1 | 2 | 3 | 4 |
| Opening a jar | 0 | 1 | 2 | 3 | 4 |
| Putting on/Lacing shoes | 0 | 1 | 2 | 3 | 4 |
| Sleeping/rolling over in bed | 0 | 1 | 2 | 3 | 4 |
| Throwing a ball | 0 | 1 | 2 | 3 | 4 |

## Lower Extremity Functional Index

Do you have difficulty performing any of the following activities in regards to your lower body?

| | | | | | |
|---|---|---|---|---|---|
| Any usual housework: cleaning, vacuuming, laundry, standing at kitchen counter cooking | 0 | 1 | 2 | 3 | 4 |
| Lifting a bag of groceries or suitcase from the floor to waist level | 0 | 1 | 2 | 3 | 4 |
| Getting into or out of the bathtub | 0 | 1 | 2 | 3 | 4 |
| Putting on/Lacing shoes | 0 | 1 | 2 | 3 | 4 |
| Squatting down to pick an object off of the floor | 0 | 1 | 2 | 3 | 4 |
| Getting into or out of a car | 0 | 1 | 2 | 3 | 4 |
| Walking | 0 | 1 | 2 | 3 | 4 |
| Going up and down stairs | 0 | 1 | 2 | 3 | 4 |
| Standing for long periods of time | 0 | 1 | 2 | 3 | 4 |
| Sitting for long periods of time | 0 | 1 | 2 | 3 | 4 |
| Rolling over in bed | 0 | 1 | 2 | 3 | 4 |