

Client Intake Form

Your Client Intake Form is important and will aid in providing information to the exercise professionals at this facility. Carefully complete the following forms as the information you provide will be assessed to provide you with the most appropriate service. If you are being treated for any health condition, **please ask that a summary be sent to us for inclusion in your health record.** **All forms are confidential.** No medical information can be released to anyone without your written permission. **A copy of these forms can be made to retain for your records.**

PLEASE PRINT

DATE: ____/____/____

LAST NAME: _____ FIRST: _____ MIDDLE INITIAL: _____

BIRTH DATE: ____/____/____ AGE: _____ SEX: F M WEIGHT: _____ LBS

HEIGHT: _____ FT _____ IN EMAIL ADDRESS: _____

HOME ADDRESS STREET: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ MOBILE: _____ WORK: _____

IN CASE OF AN EMERGENCY NOTIFY: _____ PHONE: _____

Relationship: _____

What was the date of your last physical exam? _____

Have you been under the care of a physician in the past year? Y N If yes, please explain:

Are you on any medications? Y N If yes, please explain (how many, medical conditions, etc.):

Have you ever had a maximal stress test? Y N If Yes, when: _____

Result: _____

Have you ever had surgery? Y N If yes, please explain? (please include dates and type/s of surgery):

Are you injury prone (do you tend to get injured frequently)? Y N

Do you have any diagnosed diseases/disorders (epilepsy, arthritis, heart disease, etc)? Y N

If so, please list them: _____

Do you smoke? Y N If yes, how much? _____ packs/day _____ packs/week

Do you drink alcoholic beverages? Y N If yes, how much? _____ drinks/day _____ drinks/week

Do you drink coffee? Y N If yes, how much? _____ ounces/day _____ ounces/week

Do you drink tea? Y N If yes, how much? _____ ounces/day _____ ounces/week

Do you drink soda? Y N If yes, how much? _____ ounces/day _____ ounces/week

PAR Q

- Y N 1. HAS A DOCTOR EVER SAID THAT YOU HAVE A HEART CONDITION AND RECOMMENDED ONLY MEDICALLY SUPERVISED ACTIVITY?
- Y N 2. DO YOU HAVE CHEST PAIN BROUGHT ON BY PHYSICAL ACTIVITY?
- Y N 3. HAVE YOU DEVELOPED CHEST APAIN IN THE PAST MONTH?
- Y N 4. HAVE YOU ON 1 OR MORE OCCASIONS LOST CONSCIOUSNESS OR FALLEN OVER AS A RESULT OF DIZZINESS?
- Y N 5. DO YOU HAVE A BONE OR JOINT PROBLEM THAT COULD BE AGGRAVATED BY THE PROPOSED PHYSICAL ACTIVITY?
- Y N 6. HAS A DOCTOR EVER RECOMMENDED MEDICATION FOR YOUR BLOOD PRESSURE OR A HEART CONDITION?
- Y N 7. ARE YOU AWARE, THROUGH YOUR OWN EXPERIENCE OR A DOCTOR'S ADVICE, OF ANY OTHER PHYSICAL REASON THAT WOULD PROHIBIT YOU FROM EXERCISING WITHOUT MEDICAL SUPERVISION?

IF YOU ANSWERED YES TO ANY OF THESE QUESTIONS, CALL YOUR PERSONAL PHYSICIAN OR HEALTHCARE PROVIDER BEFORE INCREASING YOUR PHYSICAL ACTIVITY.

MEDICAL CLEARANCE REQUIRED Y N

PHYSICIAN _____ PHONE# _____
FAX# _____

CLIENT CHALLENGES

How many times have you exercised for at least **20 minutes** in the past **30 days**? _____

How many times have you exercised for more than **40 minutes** in the past **30 days**? _____

How many times have you exercised for at least **20 minutes** in the past **90 days**? _____

How many times have you exercised for more than **40 minutes** in the past **90 days**? _____

How much activity do you feel you can comfortably perform right now?

What types of activities/exercises do you prefer? (aerobics, weights, sports, indoor, outdoor, etc.):

What types of activities/movements are difficult for you to perform?

Are there any specific movements that cause discomfort? If so, what movements, and where do you feel discomfort?

Do you have any pain/discomfort **during** exercise? If so, where? (include all areas)

Do you have pain/discomfort **after** exercise? If so, where?

Do you have pain/discomfort when you are **NOT** exercising? If so, where?

If you have no aches, pains or discomfort at this time, please write "No Discomfort" here: _____

During activity, do you ever experience? Shortness of breath Dizziness Headaches Cramps Coughing

CLIENT RECOVERY RATE

How important is sleep to you? Not important 1 2 3 4 5 6 7 8 9 Extremely important

How much sleep do you get? _____ hrs./night _____ hrs./week

Do you go to bed at the same time every night (most nights)? Y N

Do you wake up at the same time every morning (most mornings)? Y N

How often do you nap? (circle one)

Daily Several times/week Once/week 2-3 times/month Once/month Almost never Other _____

Do you have difficulty sleeping? Y N If so, how often? _____

When you sleep, do you rest well? Y N Do you toss and turn during sleep? Y N

Do you wake up frequently during the night? Y N

Is lack of sleep disruptive to your quality of life? Y N

How likely are you to doze off: watching TV in a car at work sitting and reading sitting and talking

Do you feel you eat a healthy diet? Y N

Please explain:

Are you currently on a "diet"? Y N If yes, what type of diet? _____

How often do you eat? _____ times/day _____ times/week

How much water do you drink? _____ oz/day _____ oz/week

Are you a vegetarian? Y N If yes, for how long? _____ yrs. _____ months

How many servings of vegetables do you eat per day? _____

How many servings of fruits do you eat per day? _____

How many servings of meat/fish do you eat per day? _____ How often do you eat fish? _____

Do you take any nutritional supplements? Y N If yes, list them? _____

Do you take any medicinal herbs? Y N If yes, list them? _____

Do you take vitamins? Y N If yes, what type? _____

Have you had a recent change in appetite? Y N Describe _____

How often do you eat in front of the TV? _____

How often do you watch TV? _____ hrs. _____ min. per day/week (circle one)

Who is responsible for your food shopping? _____ Who prepares your meals? _____

How often do you eat out? _____ How often do you eat away from home? _____

Do you have any questions or concerns with your diet? Y N Please explain

How often do you weigh yourself? _____ How much do you usually weigh? _____ lbs.

Have you had a recent weight change? Y N How much? _____ lbs. (circle one) Gained Lost

Do you feel you are: overweight under weight normal weight What is your goal weight? _____ lbs.

How much weight do you feel you need to: lose _____ lbs. gain _____ lbs.

I just need to maintain _____

Would you like to have your body composition measured? Y N

_____ % Date measured: _____

What is your occupation? _____

What is your highest level of education? _____

Have you quit smoking recently? Y N How long ago? _____

Have you quit drinking recently? Y N How long ago? _____

Under perfect circumstances, how often would you choose to exercise? _____ hrs. _____ min. per day/week

Do you have a family history of:

High Blood Pressure
Heart Disease

Diabetes
Strokes

Bleeding Diseases
Cancer

Osteoporosis
Obesity

Client Goals

My **exercise** goals are:

My **other fitness** goals are:

My **health** goals are:

My **nutrition** goals are:

My **life** goals are: _____

Other goals I have are:

Client Commitment

Merriam-Webster Dictionary:

Commit: OBLIGATE, BIND to pledge or assign to some particular course or use

I _____ commit to come to the gym _____ times/week

for at least _____ minutes/visit. I commit to working with a trainer at least _____ times/month.

I commit to work hard and focus whether I am working with my trainer or working on my own. I

commit to eating a healthy diet and living a healthy lifestyle. The aforementioned commitments include

being active when I can, making smart choices at restaurants, getting the nutrients my body needs every

day, getting the rest my body needs every night and doing my best to reduce the negative stress in my life.

Signature _____ Date _____

CANCELLATION POLICY

Trainers are required to inform all clients of the following policy for cancellation.

A client must give 24 hours advance notice prior to cancellation of a training session. If a client does cancel without the above notice he/she will be charged for the scheduled appointment.

A trainer must also give 24 hours advance notice of cancellation, if he/she does not then the client will receive a free session from the trainer.

I, _____, the client, have read the above policy and will abide.
Signature of client _____ Date _____

I, _____, the trainer, have read the above policy and will abide.
Signature of trainer _____ Date _____

This cancellation policy must be kept on file with the clients' records. Please copy this form for all clients.

Client phone number

Home _____
Work _____
Cell _____

Trainer's phone number

Home _____
Cell _____
Work 412-521-8011x267



JEWISH COMMUNITY CENTER
INFORMED CONSENT FOR EXERCISE PARTICIPATION

I desire to engage voluntarily in the JCC exercise program in order to attempt to improve my physical fitness. I understand that the activities are designed to place a gradually increasing workload on the cardiorespiratory system and to thereby attempt to improve its function. The reaction of the cardiorespiratory system to such activities cannot be predicted with complete accuracy. There is a risk of certain changes that might occur during or following the exercise. These changes might include abnormalities of blood pressure or heart rate. The activities may also be designed to place a gradual increasing workload on the muscular system and thereby attempt to improve its function. The reaction of the muscular system to such activities may include muscle soreness.

I understand that I am responsible for monitoring my own condition throughout the exercise program and should any unusual symptoms occur, I will cease my participation and inform the instructor and /or staff of the symptoms.

In signing this consent form, I affirm that I have read this form in its entirety and that I understand the nature of the exercise program. I also affirm that my questions regarding the exercise program have been answered to my satisfaction.

In the event that a medical clearance must be obtained prior to my participation in the exercise program, I agree to consult my physician and obtain written permission from my physician prior to the commencement of any exercise program.

Also in consideration for being allowed to participate in the JCC exercise program, I agree to assume the risk of such exercise, and further agree to hold harmless the JCC and its staff members conducting the exercise program from any and all claims, suits, losses, or related causes of action for damages, including but not limited to, such claims that may result from my injury or death, accidental or otherwise, during, or arising in any way from the exercise program.

(signature of participant) (date)

PLEASE PRINT:

Name _____ Date of birth ___/___/___

Address _____
street city,state,zip

Telephone (____) _____

Physician _____ Telephone (____) _____

Limitations and Medications _____

Do You Smoke? _____ History of heart disease _____ High Blood Pressure _____ Stroke _____
Weight _____ Blood Pressure _____ Health Club Member/General Member

Weight _____ History of heart disease _____ High blood pressure _____ Stroke _____

Do you smoke? _____ Health Center Member/General Member