Client Intake Form

Today's Date:_____ DOB: _____

Name: _____ Email : _____

Cell Phone: _____ Home Phone: _____

Address: _____

City Zip

How did you learn of BioFit?_____

GOALS:

1_____

2 _____

3 _____

4 On scale of 1 – 10, how much do you want to achieve your goals (10 = #1 priority) _____

BACKGROUND:

1. Medical History

A. Do you have a family history of or medical history of…

1. Heart Disease Yes No
2. Hypertension Yes No
3. Diabetes Yes No
4. Cancer Yes No
5. High Cholesterol Yes No
6. Gastrointestinal Disorders Yes No

2. Injury History

A. Do you have any injuries or limitations? No

B. Chronic or Acute? Chronic Acute

C. Do you feel discomfort with exercise? Yes No

D. Do you fell discomfort at rest? Yes No

E. Has it been diagnosed by a doctor? Yes No

F. Have you been told to avoid specific exercises? Yes No

If yes, which ones?_____

3. Exercise History

A. Recent: _____

B. Past: _____

C. Have you tracked your heart rate with your training in the past? Yes No

D. Have you ever worked with a fitness professional? Yes No

4. Nutrition History

A. # of Meals Per Day ____ Meals _____Snacks _____Oz. of Water

Breakfast: _____

Snack: _____

Lunch: _____

Snack: _____

Dinner: _____

Snack: _____

Vit/Sups: _____

B. Medicines Currently Taking: _____

5. Obstacles & Challenges

A. What makes it difficult for you to exercise on a regular basis?

Knowledge Intimidation

Motivation Boredom

Discipline Time

Accountability

B. What are you hoping to learn from this appointment today?

C. List your three most dangerous triggers. (Sensory Experience)

_____

D. List three self-defeating behaviors that would interfere with your goals. (Actions)

_____

E. List your three most high-risk situations. (Situations)

_____