Syphon fitness

Michael Kuang-NASM (CPT, CES), RYT 500, & C-IAYT

Client Intake

Name: Date:

Home Address:

City: Zip:

Email: Phone:

Date of Birth: Male: Female:

Emergency Contact:

Doctor's Name: Doctor's Phone:

How did you hear about me?

What do you want to gain from working with me?

Questions	Yes	No
Has your doctor ever said that you have a heart condition and that you should only perform physical activity recommended by a doctor?		
Do you feel pain in your chest when you perform physical activity?		
In the past month, have you had chest pain when you were not performing any physical activity?		
Do you lose your balance because of dizziness or do you ever lose consciousness?		
Do you have a bone or joint problem that could be made worse by a change in your physical activity?		
Is your doctor currently prescribing any medication for your blood pressure or for a heart condition?		
Do you know of any other reason why you should not engage in physical activity?		

If you have answered "Yes" to one or more of the above questions, consult your physician before engaging in physical activity. Tell your physician which questions you answered "Yes" to. After a medical evaluation, seek advice from your physician on what type of activity is suitable for your current condition

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Client Medical History

Physical Conditions
Describe your daily activities (Home, Work, Play). Include number of hours with each activity.
Do you have any injuries? If yes, please describe below.
How long have you had this injury?
What caused it?
Have you had any surgeries? If yes, please describe below (Include approximate date)
List any other limitations you may have physically.

Mental Health
Do you feel depressed at times?
If yes, rate it on a scale of 1 to 10. Do you know of any circumstances that may cause the depression?
Do you feel anxiety at times?
If yes, rate it on a scale of 1 to 10. Do you know what circumstances that may cause the anxiety?

Medication/Supplements
Are you taking any Prescription Medication?
If yes, please list.
Are you taking any Supplements?
If yes, please list.

Client Name (Please Print): _____

Client Signature: _____ **Date:** _____

****Office use only***

Assessment	Results
Blood Pressure	
Heart Rate (BPM)	
Respiratory Rate Per Minute	
Feet	Left: Right:
Knees	Left: Right:
Hips	Left: Right:
Back	
Shoulders & Arms	Left: Right:
Neck	