

CLIENT INFORMATION

Patient Name: _____ DOB: _____ Age: _____
Address: _____ Sex: M/F
City: _____ State: _____ ZIP _____
Home Phone: _____ Email: _____
Work Phone: _____
Cell Phone: _____

PERSONAL TRAINING

Fitness Goal 1: _____ Time Frame: _____
Fitness Goal 2: _____ Time Frame: _____
Fitness Goal 3: _____ Time Frame: _____
Past Fitness History: _____ Years Experience: _____
Fitness Eval? Yes/No Time of Day: _____

PERFORMANCE TRAINING

Performance Goal 1: _____ Time Frame: _____
Performance Goal 2: _____ Time Frame: _____
Performance Goal 3: _____ Time Frame: _____
Past Fitness History: _____ Years Experience: _____
Sports Participation _____ Season: Off/Pre/In
Multi-sport Athlete: Yes/No
If so Which Sports: _____
Any Sports Related Injuries? Yes/No
If so Please Describe: _____ Recurring Injury? Yes/No
