708 SE 4th St
College Place, WA 99324
509 540 2862

COREFIT FITNESS INTAKE

Patient Name:_____ Phone:_____ Date:_____

Date of Birth:_____ Age:_____ Occupation:_____

Address:_____ Text messages? ☐ Yes ☐ No

E-mail: _____

Would you like to receive occasional e-mails about classes, specials and updates from CoreFit? Y N

How did you hear about us?_____Whom can we thank:_____

Emergency Contact:_____

Activity History:

Y N Do you currently participate in an exercise program outside of normal daily activities?
If yes, what and how often? _____
What types of activities do you enjoy?_____

Y N Have you had any training in the Pilates Method or participated in Personal Training:
When and where?_____

Please list your top 3 goals for your fitness sessions:		What obstacles would hinder your success
1.		1.
2.		2.
3.		3.

How would you rate your overall physical fitness? Poor Fair Good Excellent

Y N Have you ever performed resistance training exercise in the past?

Y N Do you have any injuries (bone or muscle disabilities) that may interfere with exercising?
If yes, briefly describe._____

Current Health Status:

Y N Do you smoke? If yes, how much per day and what was your age when you started? _____

Y N Do you drink alcohol? If yes, how much per day and what was your age when you started? _____

Y N Do you follow or have you recently followed any specific dietary intake plan
in general, how do you feel about your nutritional habits?_____

Y N Has your weight changed more than 10 # in the last year

Y N Are you under any medical restrictions? Y N Please describe:_____
_____

Y N Have you ever been told not to participate in exercise by a health care provider? Please describe: _____
_____

Please list any medications you are currently taking and indicate their general purpose.

_____ _____
_____ _____
_____ _____

Please list any surgeries with approximate dates.

_____ _____
_____ _____

Risk factor assessment

Please mark any statements that are TRUE about your past medical history or current health condition:

_____ Heart Attack
_____ Angioplasty (PTCA)
_____ Heart Valve Disease
_____ Heart Transplantation
_____ Heart Surgery
_____ Heart Failure
_____ Rhythm Disturbance
_____ Cardiac Catheterization Coronary
_____ Pacemaker/implantable Cardiac Defibrillator
_____ Congenital Heart Disease

Have you experienced any of the following symptoms:

_____ Chest discomfort with exertion
_____ Unreasonable breathlessness
_____ Dizziness, fainting or blackouts
_____ You take heart medication
_____ Burning or cramping in your lower legs when walking short distances
_____ Musculoskeletal problems that limit your physical activities

Y N Do you currently have any concerns about the safety of exercise
Y N Is there a possibility you are pregnant

If you marked any of these statements in the above section, consult your physician or other appropriate health care provider before engaging in exercise. You may need to use a facility with medically qualified staff.

CARDIOVASCULAR RISK FACTORS Please mark any that apply:

_____ You are a male older than 45 years of age
_____ You are a woman older than 55 years of age, have had a hysterectomy, or are post-menopausal
_____ You smoke or quit smoking within the previous six months
_____ Your blood pressure is 140-190 mm Hg
_____ You do not know your blood pressure
_____ You take blood pressure medication
_____ Your blood cholesterol level is .200 mg/dl
_____ You do not know your cholesterol level
_____ You have a close blood relative who had a heart attack or heart surgery before age 55 (father/brother) or age 65 (mother/sister)
_____ You have a close blood relative who had congenital heart disease, high blood pressure, high cholesterol or diabetes.
_____ You are physically inactive (ie, you get <30 minutes of physical activity on at least three days per week)
_____ You are >20 pounds overweight

If you marked two or more of the statements in the above section, you should consult your physician or other appropriate health care provider before engaging in exercise. You might benefit from using a facility with professionally qualified exercise staff to guide your exercise program.

_____ None of the above conditions apply to me

You should be able to exercise safely without consulting your physician or other appropriate health care provider in a self-guided program or almost any facility that meets your exercise program needs.

OTHER MEDICAL HISTORY

CURRENT MEDICAL CONDITIONS			
Yes	**No**	**Condition**	**Onset/Duration**
		Asthma or other Lung Disease	
		Blacking out	
		Blood Clots	
		Cancer, specify area	
		Carpal Tunnel Syndrome	
		Contractible Disease	
		Edema (swelling in ankles)	
		Epilepsy / Seizures	
		Fibromyalgia	
		Gait / Balance problems	
		Hearing problems	
		Low Blood Pressure	
		Major Spinal Surgery	
		MRSA or Staph Infection	
		Multiple Sclerosis	
		Pregnancies	
		Rheumatic Fever	
		Severe Allergies	
		Stroke	
		Visual/ Speech acuity short-term or temporary loss	

CURRENT MUSCULOSKELETAL CONDITIONS			
Yes	**No**	**Condition**	**Onset/Duration**
		Ankle / Foot Pain	
		Arthritis, specify location	
		Breathing difficulties (at night, sudden onset, when lying down)	
		Elbow / Hand Pain	
		Fatigue (with usual activities)	
		Headaches	
		Herniated Disc	
		Hip / Knee Pain	
		Low Back Pain	
		Muscle / Ligament / Tendon Injuries	
		Neck / Jaw Pain	
		Neurological Condition	
		Osteoporosis	
		Sciatica	
		Shoulder Pain / Dislocations	
		Tingling / Numbness / Weakness / Cramping	
		Joint Replacements, please specify	
		Upper back Pain	

OTHER			
Yes	**No**	**Condition**	**Onset/Duration**
		Are you currently under Worker's Compensation Claim?	
		Are you currently under an Automobile Insurance Claim?	
		Accident(s) resulting in injury	
		Please Describe:	