Client Readiness Assessment

Name:_____Age:_____DOB:_____

Home phone:_____Work/Cell:_____

How did you hear about us?_____

Important: *If age 15 to 69 complete PAR-Q form. (See our website link)*
If over age 69, please obtain doctor consent, verbally, or in writing, prior to starting program.

Goals
To be successful we need to give your mind a clear picture of where you want to be in in 6 weeks, 6 months, and 2 years from now...Describe what you want to accomplish. In how much time?

Medical Conditions
1.Blood Pressure(systolic/diastolic):_____ 2.Cholesterol(mg/dl)_____
3.History of Family Heart Disease (Mother, father, siblings, before age 55)? YES/NO_____
4.Weekly Alcohol Consumption (Wine, beer, hard liquor): _____
5.Smoking (If Yes, how many/day?): YES/NO_____
6.Prescription Drugs:_____
7. Range of Motion limitations (Below, please circle any that apply):

Neck Shoulders Back Hips Knees Hands Feet Elbows Wrists Other

Do you have any injuries or limitations that would hamper you during exercise? Any serious accidents?

Exercise History
Are you on a regular exercise program now? If not, what have you done in the past?

When was the last time you felt like you were physically fit?

What do you like about working out? What don't you like?

What is a typical day in your life with regard to sleep, food, water, stress, supplements, alcohol?