DS FITNESS CLIENT INTAKE FORM

Contact Information: Please print clearly

Name: ______________________________

❑ Male ❑ Female Date of first session: ____________ Date of Birth: ____________ DD/MM/YY

Address: ______________________________

City: ____________ Provence: ____________ Postal Code: ____________

Home #: ____________ Mobile #: ____________

Email: ______________________________

Emergency Contact Name: ____________ Phone: ____________

How did you hear about us? ______________________________

Medical Information: Please check all that apply and provide detailed information below.

- ❑ Back Problems
- ❑ Osteoporosis
- ❑ Fibromyalgia
- ❑ Balance problems
- ❑ Medications
- ❑ Allergies
- ❑ Heart attack, heart disease, cardiac surgery, pacemaker
- ❑ Diabetes
- ❑ Epilepsy
- ❑ Blood pressure problems
- ❑ Migraines or recurrent headaches
- ❑ Swollen, stiff, or painful joint
- ❑ Lightheadedness or fainting
- ❑ Asthma
- ❑ Stomach or intestinal problems
- ❑ Hernia
- ❑ Bursitis
- ❑ Skin condition
- ❑ Other

Details: ______________________________

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Are you presently engaged in regular exercise or physical activity? If yes, please list activity, duration, frequency, and intensity. ______________________________

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Have you had a recent medical examination? Were the results satisfactory?

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