



## NEW CLIENT INTAKE FORM/HEALTH HISTORY QUESTIONNAIRES

Date: \_\_\_\_\_

Name: \_\_\_\_\_

Date of birth: \_\_\_\_\_

Address: \_\_\_\_\_

Street City State Zip: \_\_\_\_\_

Phone (H): \_\_\_\_\_ (W): \_\_\_\_\_ (C): \_\_\_\_\_

E-mail address: \_\_\_\_\_

*In case of emergency, whom may we contact?*

Contact 1: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone (H): \_\_\_\_\_ (W): \_\_\_\_\_ (C): \_\_\_\_\_

Contact 2: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone (H): \_\_\_\_\_ (W): \_\_\_\_\_ (C): \_\_\_\_\_

**Primary Care Provider**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

## PLEASE ANSWER THE FOLLOWING: PAST/PRESENT HISTORY

**Have you had OR do you presently have any of the following conditions? (Check if yes.)**

- Rheumatic fever
- Recent operation
- Edema (swelling of ankles)
- High blood pressure
- Injury to back or knees

**If yes, please explain:** \_\_\_\_\_

\_\_\_\_\_

- Low blood pressure
- Seizures
- Lung disease
- Heart attack
- Fainting or dizziness with or without physical exertion
- Diabetes
- High cholesterol
- Orthopnea (the need to sit up to breathe comfortably) or paroxysmal (sudden, unexpected attack) nocturnal
- Dyspnea (shortness of breath at night)
- Shortness of breath at rest or with mild exertion
- Chest pains
- Palpitations or tachycardia (unusually strong or rapid heartbeat)
- Intermittent claudication (calf cramping)
- Pain, discomfort in the chest, neck, jaw, arms, or other areas with or without physical exertion
- Known heart murmur
- Unusual fatigue or shortness of breath with usual activities
- Temporary loss of visual acuity or speech, or short-term numbness or weakness in one side, arm, or leg of your body
- Other

**If yes, please explain:** \_\_\_\_\_

\_\_\_\_\_

## PLEASE ANSWER THE FOLLOWING: FAMILY HISTORY

**Have any of your first-degree relatives (parent, sibling, or child) experienced the following conditions? (Check if yes.)**

**In addition, please identify at what age the condition occurred at the bottom in the notes section.**

- Heart arrhythmia
- Heart attack
- Heart operation
- Congenital heart disease
- Premature death before age 50
- Significant disability secondary to a heart condition
- Marfan syndrome
- High blood pressure
- High cholesterol
- Diabetes
- Other major illness

**If yes, please explain:** \_\_\_\_\_

\_\_\_\_\_

**Additional Notes:** \_\_\_\_\_

\_\_\_\_\_

## PHYSICAL ACTIVITY READINESS QUESTIONNAIRE (PAR-Q)\*

	Questions	Yes	No
1	<i>Has your doctor ever said that you have a heart condition and that you should only perform physical activity recommended by a doctor?</i>		
2	<i>Do you feel pain in your chest when you perform physical activity?</i>		
3	<i>In the past month, have you had chest pain when you were not performing any physical activity?</i>		
4	<i>Do you lose your balance because of dizziness or do you ever lose consciousness?</i>		
5	<i>Do you have a muscle, bone, joint or back problem that could be made worse or aggravated by exercise or a change in your physical activity?</i>		
6	<i>Is your doctor currently prescribing any medication for your blood pressure or for a heart condition?</i>		
7	<i>Do you know of <b>ANY</b> other reason why you should not engage in physical activity such as (but not limited to) a fitness training program, a fitness training program for client/dog, fitness assessment or nutritional program?</i>		

*\*If you answer "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. Written, signed approval will be required from your physician prior to starting a fitness program with K9 Fit Club LLC. The written approval will need to list all exercise restrictions.*

**I understand that by signing below I am acknowledging that I have read all of the above questions and paragraph following those questions, and answered honestly. I also understand and acknowledge that answering "yes" to any of the above answers requires a consult with my physician prior to engaging in any physical activity. I will also need written signed approval from my physician with a list of any exercise restrictions (if any) before taking part in any K9 Fit Club Fitness activities.**

Client Name (Printed): \_\_\_\_\_

Date: \_\_\_\_\_

Client Name (Signature): \_\_\_\_\_

## ACTIVITY & LIFESTYLE HISTORY

1. How were you referred to this program? *(Please be specific)*

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2. Why are you enrolling in this program? *(Please be specific)*

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3. Are you presently employed? YES  NO

4. What is your present occupational position?

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Name of company:

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On a scale from 0-10, with 0 equal to none and 10 equal to extreme, how would you rate your daily stress level?

0    1    2    3    4    5    6    7    8    9    10

5. Have you worked with a personal trainer before? YES  NO

6. What was the date of your last physical examination performed by a physician? \_\_\_\_\_

7. Do you participate in a regular exercise program at this time? YES  NO

*If yes, briefly describe:*

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8. What are your desired days and times for classes or private sessions? *(Select all that apply)*

M      T      W      TH      F      S      S

- Morning: 6am-10am
- Afternoon: 12pm-3pm
- Evening: 5pm-8pm

9. What type of classes are you most interested in? *(Select all that apply)*

- Private human instruction
- Human group classes
- Private canine instruction
- Canine group classes
- Private human/canine instruction
- Human/canine group classes

10. Do you smoke? YES  NO  *If yes, how much per day and what was your age when you started?*

Amount per day: \_\_\_\_\_ Age: \_\_\_\_\_

11. Do you follow or have you recently followed any specific dietary intake plan, and in general how do you feel about your nutritional habits?

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12. List any medications you are presently taking.

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13. List in order your personal health and fitness objectives.

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**I understand that by signing below I am acknowledging that I have read all of the above questions and answered honestly.**

*Client Name (Printed):* \_\_\_\_\_

*Date:* \_\_\_\_\_

*Client Name (Signature):* \_\_\_\_\_