santa cruz core FITNESS + REHAB

Date Seen: _____ By: _____ Consult With: _____

Client Information

Name: _____

Age: _____ Date of Birth: _____

Address: _____

City: _____ Zip: _____

Email: _____

Cell #: _____ Service Provider: _____

Home #: _____

Best way to contact me would be: ☐ Cell ☐ Home ☐ Work

Opt out of text message reminder? ☐ Yes ☐ No

Occupation / Employer: _____

Emergency Contact: _____

Phone: _____

Fitness Goals

☐ Weight Loss / Gain ☐ ▼ Body Fat ☐ Improve Diet

☐ ▲ Strength ☐ ▲ Flexibility ☐ Improve Cardiovascular

☐ Other: _____

Exercise History

What have you done in the Past? ☐ Weights ☐ Cardio

☐ Yoga ☐ Kettle Bell ☐ Cross Fit ☐ Pilates ☐ Plyometrics

☐ Functional Training ☐ Other: _____

Currently Doing? _____

How many days per week? ☐ 0-1 ☐ 2-3 ☐ 2-4 ☐ 3-5 ☐ 6-7

Have you worked with a personal trainer? ☐ Yes ☐ No

What services are you interested in?

☐ Massage Therapy ☐ Personal Training ☐ Chiropractic

☐ Acupuncture ☐ Physical Therapy ☐ Nutrition Counseling

☐ Weight Loss Program ☐ Semi Private Training ☐ Yoga

What group classes are you interested in?

☐ Pilates ☐ Circuit Training ☐ Get on the Ball ☐ Yoga

☐ Boot Camps ☐ Functional Fitness ☐ Fitness Challenge

☐ Core Conditioning

How did you hear about us?

☐ Google ☐ Facebook ☐ Yelp ☐ Internet ☐ Phonebook

☐ Newspaper ☐ Flyer ☐ Other: _____

☐ Friend / Family. Whom might we thank for referring you?

Name: _____

Refer a friend for a FREE consultation

Name: _____

Phone / Email: _____

Name: _____

Phone / Email: _____

Get a $5 credit for each of the following:

☐ Google Review ☐ Yelp Review ☐ Yahoo Review

☐ Bing Review ☐ Like or Check in on Facebook

☐ Link to our Website

Orthopedic Limitations

	Neck	Back	Hip	Knee	Ankle	Shoulder	Wrist
Recent Injury	☐R ☐L	☐R ☐L	☐R ☐L	☐R ☐L	☐R ☐L	☐R ☐L	☐R ☐L
Weak, not chronic	☐R ☐L	☐R ☐L	☐R ☐L	☐R ☐L	☐R ☐L	☐R ☐L	☐R ☐L
Chronic, not severely limiting	☐R ☐L	☐R ☐L	☐R ☐L	☐R ☐L	☐R ☐L	☐R ☐L	☐R ☐L
Chronic, severely limiting	☐R ☐L	☐R ☐L	☐R ☐L	☐R ☐L	☐R ☐L	☐R ☐L	☐R ☐L

Please describe the foods you eat in a typical day

Time: _____ Breakfast: _____

Time: _____ Snack: _____

Time: _____ Lunch: _____

Time: _____ Snack: _____

Time: _____ Dinner: _____

Wellness Manager: _____ Plan: _____ Purchased: _____

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Surgeries / Hospitalization

What surgeries, operations, traumas, fractures, car accidents, etc. have you had? _____

Medication

Please list any medication you are taking, or have taken in the past, and for how long. State the reason for taking it: _____

Stress Level

Rate your stress level currently on a scale from 1 - 10 (10 being most stressed). Note that stress can come in forms such a over-worked, relationships, health concerns, tiresome family or work responsibilities, excessive fear, worry, anxiety, insomnia, road rage, etc.

Overall Stress: _____

Main Reason for Stress: _____

If over 5, what steps are you currently taking to reduce your stress? _____

Energy Level

On a scale of 1 - 10 (10 being highest) what is your energy level during the following times:

AM: _____ Afternoon: _____

Evening: _____ Late PM: _____

After meals: _____ Overall: _____

Daily Habits

For each item listed below specify if you consume them and how often, i.e. 2 cups / day:

Coffee / Tea: _____

Soda: _____

Alcohol: _____

Water: _____

Fast Food: _____

Tobacco: _____

Vitamins / Minerals: ☐ Multi ☐ Vit D ☐ Omega 3

Sleep Quality

How is your sleep? (check all that apply)

☐ Restful ☐ Restless ☐ Hard to get sleep

☐ Wake up often ☐ Nightmares ☐ On Back

☐ On Side ☐ On Stomach

What time do you usually go to sleep? _____

Hours of sleep / night? _____

Family History

	Maternal		Paternal							
	Grandma	Grandpa	Grandma	Grandpa	Mother	Father	Brother	Sister	Onset	Outcome
Allergies	☐	☐	☐	☐	☐	☐	☐	☐		
Arthritis (type)	☐	☐	☐	☐	☐	☐	☐	☐		
Asthma	☐	☐	☐	☐	☐	☐	☐	☐		
Cancer (type)	☐	☐	☐	☐	☐	☐	☐	☐		
Diabetes	☐	☐	☐	☐	☐	☐	☐	☐		
Heart Disease	☐	☐	☐	☐	☐	☐	☐	☐		
Mental Disease	☐	☐	☐	☐	☐	☐	☐	☐		
Thyroid Imbalance	☐	☐	☐	☐	☐	☐	☐	☐		

Other _____

Review of Systems

GENERAL	Now	Ever
Weight loss	☐	☐
Weight gain	☐	☐
HEAD		
Headache	☐	☐
Dizziness	☐	☐
Head trauma	☐	☐
Fainting	☐	☐
Blacking out	☐	☐
EYES		
Change in vision	☐	☐
Cataracts	☐	☐
Light sensitivity	☐	☐
Flashes in vision	☐	☐
Spots in vision	☐	☐
EARS		
Hearing difficulty	☐	☐
Earaches	☐	☐
Discharge	☐	☐
Ringing	☐	☐
NOSE		
Nosebleeds	☐	☐
Sinus problems	☐	☐

MOUTH	Now	Ever
Bleeding gums	☐	☐
Cold sores	☐	☐
Dentures	☐	☐
Sore throat	☐	☐
Jaw pain	☐	☐
Changes in taste	☐	☐
Hoarseness	☐	☐
SKIN		
Rash	☐	☐
Bruising	☐	☐
Brittle nails	☐	☐
Changes in mole	☐	☐
Itching	☐	☐
LUNGS		
Difficulty breathing	☐	☐
Asthma	☐	☐
Pneumonia	☐	☐
Wheezing	☐	☐
Persistent cough	☐	☐
Coughing phlegm	☐	☐
Coughing blood	☐	☐
Tuberculosis	☐	☐

VASCULAR	Now	Ever
Chest pain	☐	☐
Palpitations	☐	☐
Ankle Swelling	☐	☐
Cold feet / hands	☐	☐
Leg cramps	☐	☐
Calf pain	☐	☐
Varicose veins	☐	☐
Low blood pressure	☐	☐
High blood pressure	☐	☐
G-I SYSTEM		
Gas	☐	☐
Heartburn	☐	☐
Indigestion	☐	☐
Ulcers	☐	☐
Vomiting/Nausea	☐	☐
Abdominal pain	☐	☐
Diarrhea	☐	☐
Constipation	☐	☐
Blood in stool	☐	☐
Hemorrhoids	☐	☐
Gail bladder disease	☐	☐
Liver disease	☐	☐

G-U SYSTEM	Now	Ever
Difficulty urinating	☐	☐
Pain urinating	☐	☐
Blood in urine	☐	☐
Incontinence	☐	☐
Foul odor of urine	☐	☐
Increased urination	☐	☐
Decreased urination	☐	☐
Urinary infection	☐	☐
Genital infection	☐	☐
NEUROLOGICAL		
Seizure / epilepsy	☐	☐
Stroke	☐	☐
Tingling sensation	☐	☐
Numbness	☐	☐
Weakness	☐	☐
Difficulty walking	☐	☐
Poor coordination	☐	☐
MUSCLE / BONE		
Joint Pain	☐	☐
Arthritis	☐	☐
Bone pain	☐	☐
Fracture	☐	☐

CONDITIONS	Now	Ever
Pregnant	☐	☐
Diabetes	☐	☐
Thyroid condition	☐	☐
Heart condition	☐	☐
Rheumatic arthritis	☐	☐
Rheumatic fever	☐	☐
Glaucoma	☐	☐
Alcoholism	☐	☐
Cancer / tumor	☐	☐
Polio	☐	☐
Parkinson's	☐	☐
Multiple Sclerosis	☐	☐
Gout	☐	☐
Anemia	☐	☐
Osteoporosis	☐	☐
Osteoarthritis	☐	☐
High cholesterol	☐	☐
TIAs	☐	☐
Pacemaker	☐	☐
Stroke	☐	☐
Allergies	☐	☐