Fitness Therapy
Science. Sweat. Mindset

CLIENT APPLICATION

Client Name
Address 1
Address city/state
email

Date of form completion:

Please take your time in providing the following information. The questions are designed to help me begin to understand you so that our time together can be as productive as possible. All information provided is confidential.

Physical Wellbeing

Age: Height: Weight:

How would you rate your current physical health?

- ☐ Poor
- ☐ Unsatisfactory
- ☐ Satisfactory
- ☐ Good
- ☐ Very Good

Please note health concerns, prior injuries and/or contraindications to exercise.

Briefly describe your current exercise regiment:

Briefly describe your athletic / fitness experience.

Which exercise modalities would you like to improve on and / or learn?

Are there exercises and/or modalities of which you are opposed?

What are your primary physical goals?

Do you have access to a fitness facility? Please describe or provide pictures and / or website link.

Emotional Wellbeing

Briefly describe how you currently handle stress in your life:

What obstacles (physical or emotional) do you foresee as barriers to achieving your goals?

What are your primary mental / emotional goal?

Do you believe you are in control of your own thoughts and actions?

Are you currently experiencing anxiety, stress?

- ☐ Yes
- ☐ No

If yes, when did you begin experiencing this? _____

Please describe any major losses or traumas you have experienced:

What significant life changes or stressful events have you experienced recently?

What would you like to accomplish out of your time in Fitness Therapy?

Interpersonal Wellbeing

Who is your support group in your life? Who do you turn to / lean on?

Marital Status:

- ☐ Never Married
- ☐ Domestic Partner
- ☐ Married
- ☐ Separated
- ☐ Divorced -- For how long?
- ☐ Widowed: Please provide your partners name and year deceased:

If married, how long have you been married for and what is your partners name:

_____

On a scale of 1-10 (best), how would you rate your relationship? _____

Are you currently in a romantic relationship?

- ☐ Yes -- How long? _____
- ☐ No

On a scale of 1-10 (best), how would you rate your relationship? _____

Please list any children, their names, and ages:

Name	Age	Relationship	Name of other parent	If deceased, age and cause of death

Nutritional Habits

Briefly describe your nutritional habits during the week:

Briefly describe your nutritional habits during the weekend:

Are you currently following any specific diet, or have you previously?

Please list any food allergies:

Where do you eat most of your meals?

How many glasses of water do you drink each day?

I consume an average of _____ alcoholic drinks per (circle one) night/week/month.

Please list any supplements you currently take:

Sleep Hygiene

How would you rate your current sleeping habits?

- ☐ Poor
- ☐ Unsatisfactory
- ☐ Satisfactory
- ☐ Good
- ☐ Very Good

If you are having problems, in which phase of sleep are you experiencing issues?

- ☐ Falling asleep
- ☐ Staying asleep
- ☐ Awakening early
- ☐ Sleep apnea

Please list any other specific sleep problems you are currently experiencing:

Additional Information

Please describe current use of alcohol, cigarettes, and/or recreational drugs:

Please describe previous use of alcohol, cigarettes, and/or recreational drugs:

What do you enjoy about your work (full-time homemaker included)? If retired, what did you enjoy about your work?

What do you find particularly stressful about your current or previous work?

What do you enjoy doing in your free time? What do you do to relax?

Do you consider yourself to be spiritual or religious? If yes, please describe your faith or belief:

What do you consider to be some of your strengths?

What do you consider to be some of your weakness?