PROGRESSION

Corrective Movement Therapies & Athletics

Today's Date _____

Name _____ Gender: M ☐ F ☐ DOB _____ Age _____

Mailing Address _____ Email _____

Home Phone _____ Work Phone _____ Mobile _____

Emergency Contact _____ Home _____

Please answer carefully and completely. The information is for the sole purpose of developing and implementing your personal MAT and fitness program. Your signature on the last page verifies your explicit consent to share medical and fitness history with your personal trainer at Progression - Corrective Movement Therapies & Athletics. All content herein is private and restricted from outside parties.

PART 1 – Medical History

1. Who are your primary and secondary medical providers? (PCP, OBGYN, psychiatrist, chiropractor, etc.) Please include full name, address and reason for seeing. *This is optional for now, but practitioner may request specific information later to interface with other professionals regarding care/treatment. As well, radiological information or blood panel may be helpful.*

Name	Address and Phone	Care Provided

2a. Please list any medications you are currently taking. (Use reverse side of page if needed)

Name of medication	Dosage	Why & How long have you been taking this medication?

2b. Please list any meds you have taken in the past for more than six months but no longer take and why you started and stopped.

Name of medication	Why did you stop taking this medication?

2c. Do you take ***any*** nutritional/dietary supplements? If so please list below. Continue on back if necessary.

Name of Supplement	Dosage	Why & How long have you been taking this supplement?

4a. Do you presently have, or in the past suffered, from any of the following issues:

ISSUES	YES	NO
A. Has your Doctor diagnosed, or do you have a history of heart problems, chest pain, or stroke?	☐	☐
B. Has an immediate family member (parent/sibling) had a heart attack, stroke or cardiovascular disease before the age of 55 yrs old?	☐	☐
C. Do you frequently have pains in your heart and/or chest when you do physical activity?	☐	☐
D. Do you lose balance because of dizziness or do you ever lose consciousness?	☐	☐
E. Is your doctor(s) currently prescribing drugs for blood pressure or heart condition? See Question #2	☐	☐
F. Are you over the age of 65 and not accustomed to vigorous exercise?	☐	☐
G. High Cholesterol or HDL:LDL imbalance	☐	☐
H. Do you currently smoke? Cigarette, cigar, pipe smoking How Much How Long	☐	☐
I. Obesity	☐	☐
J. Asthma or Breathing trouble	☐	☐
K. Have you ever had a stroke or heart attack?	☐	☐
L. Are you a male greater than 45 yrs old? ☐ Are you a female greater than 55 yrs old? ☐		
M. (Females) Pregnancy currently or within last 12 months	☐	☐
> How many children have you had?		
N. Learning disabilities or cognitive challenges	☐	☐
0. Do you consume any alcoholic beverages? (Beer, wine, liquor, etc.)	☐	☐
> Please indicate in ounces how much alcohol you consume weekly		oz
P. Do have difficulty swallowing food or chewing food?	☐	☐
Q. Is there any reason not mentioned thus far to preclude you from regular exercise activity?	☐	☐
R. Do you have urinary incontinence?	☐	☐

4b. Please elaborate here if you checked “yes” for letters A, C, D, J, N, and O.

5. Do you use any non-prescription drugs (marijuana, cocaine, etc.)

6. Trauma/Injury/Surgery History (Every significant physical pain you have experienced) includes even what you might consider minor, non-medically treated injuries.

Please complete the following information as completely and thoroughly as possible. This is an extremely important section of this questionnaire.

Body Part	1-18 years	19 - 29 years	30 – 45 years	46 - 60 years	60 + years
Head/Jaw i.e. Clicking jaw, concussion,					
Cervical/ Neck i.e. whiplash,					
Thoracic/ Mid back					

Lumbar/ Low back					
Abdominals/ Ribs Hernia					
Pelvis/Hips Femur/Thigh					
Shoulder/ Scapulae/ Rotator cuff					
Elbow i.e. tennis elbow					
Wrist/Hand Fingers Carpal Tunnel					
Knees Patella, ACL, Tendonitis					
Ankles/Feet Do you wear Orthotics?					

7. Have you had any cosmetic/plastic surgery? Please describe below. (breast augmentation, tummy tuck, botox)

8. Diagnosed Diseases. Please Provide all medical reports (X-rays/MRI/CT Scan)

Diagnosed Diseases	**Initial Diagnosis**
Orthopedic (i.e. Spinal fusion, Knee joint replacement)	
Metabolic (i.e. Diabetes, Hypothyroid)	
Neurological (i.e. Stroke, Parkinson's)	
Dental Work (Braces/Night Bite Plates, Appliances, orthodontics)	

9. Describe any physical and emotional stressors you may experience performing your duties. Please include indication of frequency, magnitude, and duration.

10. Please prioritize the severity (#1 is the worst or greatest concern) of your current physical pain/discomfort

1.	
2.	
3.	
4.	

11. If you feel that you are experiencing unusual levels of stress in one or more of the following areasPlease check 'Yes' or 'No'

Home	Yes ☐	No ☐
Work/School	Yes ☐	No ☐
Financial	Yes ☐	No ☐
Relational	Yes ☐	No ☐

12. Please describe a typical day of activity for you.

Example: "My morning Starts at 6:00 am and I drink a cup of coffee and drive to work. I sit at a desk until noon and order lunch from a local restaurant. I typically work through lunch. I sit at a computer and talk on the phone and end my work day at 6pm. I drive home, pick up my kids and eat dinner around 7pm. I do house chores and am in bed by 11pm."

13. Please describe your shoe wear? What do you wear the most throughout the week?

14. Are you sleeping well?

15. What are your daily work duties/demands?

16. What physical activities and/or physical positions can you not perform without discomfort or significant tension? (I.e. kneeling down, reaching overhead)

17. What self-care strategies do you currently use to manage your own health and why? (Ice packs, stretching, acupuncture, magnets, heating pad, massage, etc.)

18. Do you play a musical instrument? If so, which instrument, how long, how many hours of practice/week?

19. What have you found to be positions of relief or things you do to manipulate your own body during the day to deal with any pain or discomfort?

20. Do you have confusion or frustration regarding exercise and wellness strategies – conflicting advice or information you have been given or read yourself?

21. Do you feel that with each passing year you are getting healthier or unhealthier? Explain.

22. Please include any additional comments or concerns you may have (use back if needed)

Part 2 – Fitness and Wellness

1. Have you consulted with a physician regarding diet and exercise? If yes, please describe the recommendations.

2. Have you in the past, or are you currently following a special diet or eating program? Please describe.

3. What, if any, changes would you like to make to your current eating habits?

4. Please list and rate the goals for your movement/exercise program as far as how close or far you are from reaching them right now; Select a number each goal listed.

Your Goals	**Far**				**half**	**way**				**Done**
	1 ◯	2 ◯	3 ◯	4 ◯	5 ◯	6 ◯	7 ◯	8 ◯	9 ◯	10 ◯
	1 ◯	2 ◯	3 ◯	4 ◯	5 ◯	6 ◯	7 ◯	8 ◯	9 ◯	10 ◯
	1 ◯	2 ◯	3 ◯	4 ◯	5 ◯	6 ◯	7 ◯	8 ◯	9 ◯	10 ◯
	1 ◯	2 ◯	3 ◯	4 ◯	5 ◯	6 ◯	7 ◯	8 ◯	9 ◯	10 ◯
	1 ◯	2 ◯	3 ◯	4 ◯	5 ◯	6 ◯	7 ◯	8 ◯	9 ◯	10 ◯

5. Please describe your current exercise program:

How often per month?	
How long is each session?	
What type of exercise?	
Where do you exercise?	

6. How long have you participated in regular exercise programs?

7. Select your perception of the overall effort of your program? (1 - very easy, 10 - very hard)

1 ◯	2 ◯	3 ◯	4 ◯	5 ◯	6 ◯	7 ◯	8 ◯	9 ◯	10◯

8. Please select your exercise participation for each age range through to present age (1 = rarely, 10 = often)

15 – 20 years	1 ◯	2 ◯	3 ◯	4 ◯	5 ◯	6 ◯	7 ◯	8 ◯	9 ◯	10 ◯
21 – 30 years	1 ◯	2 ◯	3 ◯	4 ◯	5 ◯	6 ◯	7 ◯	8 ◯	9 ◯	10 ◯
31 – 40 years	1 ◯	2 ◯	3 ◯	4 ◯	5 ◯	6 ◯	7 ◯	8 ◯	9 ◯	10 ◯
41 – 50 years	1 ◯	2 ◯	3 ◯	4 ◯	5 ◯	6 ◯	7 ◯	8 ◯	9 ◯	10 ◯
51 – 60 years	1 ◯	2 ◯	3 ◯	4 ◯	5 ◯	6 ◯	7 ◯	8 ◯	9 ◯	10 ◯
60 +	1 ◯	2 ◯	3 ◯	4 ◯	5 ◯	6 ◯	7 ◯	8 ◯	9 ◯	10 ◯

9. Were you a high school or college athlete? Please list sports and positions

10. Do you own any exercise equipment? Please list

11. How would you like your goals measured? (Against others in your age/gender, against baseline, etc.)

12. What time frame would you like to plan for each training period goal? (I.e. every 4 weeks, every 3 months)

13. What would you perceive as challenging when you are exercising? How would you know that yourindividual exercise session is a success each time? (Exhaustion, refreshed, a little sweaty, etc.)

14. What are your expectations for the exercise experience?

15. What do you think would happen if you stopped for 3 – 4 weeks?

16. In what way would you like to receive feedback from the trainer about your progress? (Verbal, written)

17. Have you started exercise programs in the past or joined gyms and stopped? Why?

18. What are the possible reasons you would not complete your training program and embrace exercise as a lifelong, lifestyle/process?

19. What do you believe is necessary in order for you to change your body to the way you want? (i.e. eating less, eating more frequently, rigorous exercise, etc.)

20. How would you like to be rewarded, and what is the basis for the reward, when you reach your set goals?

Client Signature _____ Today's Date _____