Client Assessment

BASIC INFORMATION

*Would you like to receive the online Next Level Newsletter? **YES___**
***check appropriate box**
(Newsletter contains fitness tips and facts)

Last Name:_______________ First Name:______________ D.O.B.___/___/___

Address:________________________ City:______________ State:_____ Zip:_____

Home Phone:(____)_______________ Email:_________________________________

Emergency Contact:__________________ Emergency #(____)____________________

Client Consent

By signing this consent, you are agreeing to the requirements and stipulations of Next Level Athletic Performance. Print and Sign your name in the spaces provided below.

I ______________________________, agree to participate in the Next Level Athletic Performance program, and understand that this program is not medically supervised. This program is designed for healthy individuals with no existing medical conditions or risks (physical or psychological). If I have an existing medical condition, before I can begin training, I will present to you a Physician's Release Form, which has been signed and dated. This form represents my physician's approval for my participation in the Next Level Athletic Performance Program. I grant permission to Next Level Athletic Performance to contact my physician or health care professional if I require medical supervision during my training.

Client Signature:_____________________________ Date:_____________

M.D. Name _____________________________ Phone:____________
Address: _____________________________
____

LIFESTYLE QUESTIONS

Do you know how many calories you consume in a day?___________________________

How many meals do you normally eat in a day?__________________________________

What are your favorite foods?____

What are your least favorite foods?____

Do you take a multivitamin?____________________ if so, what brand?________________

Do you smoke?___________ if so, how many per day?____________

Do you drink alcohol?____________ if yes, how many drinks per week?_____________

Are you currently doing cardiovascular/aerobic exercise?___________________________
Type of exercise?________________ How many days a week?___________
Duration______

Are you currently strength training?________ How many days a week?_____________
Full body or Split Routine?_______________

On a normal day do you participate in flexibility training?__________
What kind of stretching?________________________

Would you be interested in group personal training/ bootcamps?___________________

What are your hobbies?____
____
____

Please List the Name and # of 3 people you know who would benefit from our services.

1) Name:__________________________________ #:__________________

2)Name:__________________________________ #:__________________

3)Name:__________________________________ #:__________________

HEALTH ASSESSMENT
(circle one)

1)	Do you suffer from backpain?	Yes	No
2)	Are you sensitive to touch or pressure in any one area?	Yes	No
3)	Do you have any tension or soreness in any one area?	Yes	No
4)	Do you have numbing or stabbing pains anywhere?	Yes	No
5)	Do you experience frequent headaches?	Yes	No
6)	Do you have high blood pressure?	Yes	No
7)	Are you epileptic?	Yes	No
8)	Have you ever broken a bone?	Yes	No
9)	Do you experience stiff or swollen joints?	Yes	No
10)	Do you experience fatigue or lack of energy?	Yes	No

HEALTH HISTORY
Check all conditions that apply and list any medications that you are currently taking.

__ Heart Disease
__ High Blood Pressure
__ High Triglycerides
__ Lung Disease
__ Food Allergies
__ Neuromuscular Disease
__ Gastrointestinal Disease
__ Obesity
__ Psychological Problems
__ Anorexia
__ Arthritis
__ Kidney Disease
__ Depression
__ Diabetes Mellitus
__ Cancer
__ Compulsive Overeating
__ Pregnant
__ Diarrhea
__ Anemia
__ Special Diet
__ Ulcer
__ Bulimia
__ Thyroid Disease
__ Osteoperosis

Please list other conditions:____

Medications taken:____

TRAINER USE ONLY:
Client Body Composition:

*Body Fat %______________ date:_____________
*Flexibility notes:____
____
____
____

*Postural Assessment: Overhead Squat_____________________________________
SL Squat __________