Just FIT Studio

**Personal Training**



# Confidential Patient Case History

Name: _____ Date: Phone Number: _____
Birthdate: Age: Weight: Height: _____
How did you hear about Rick Pollock/Just Fit Studio? _____
Are you taking any Medications? ___Why? _____
Have you had any surgeries in the past five years?____ Please list condition and month/year.
_____
What type of exercise have you participated in the last three months? _____
_____
What are your fitness goals?_____
Do you have any conditions the might affect your workout or safety?_____
_____

**Basic Information:**

Drugs you now take: [ ] Anti-Inflammatory [ ] Painkiller [ ] Muscle Relaxants [ ] Anti-depressants
[ ] Tranquilizers [ ] Birth control Pills [ ] Others:_____
Age of Mattress:_____ [ ] Comfortable [ ] Uncomfortable
Do you sleep mainly on your: [ ] Side [ ] Back [ ] Stomach
Are you wearing: [ ] Arch Supports [ ] Inner Soles [ ] Heel lifts [ ] Sole Lifts
Have you been in an auto accident: [ ] Past Year [ ] Past five years [ ] Over five years [ ] Never
Describe any injuries:_____
_____

**Preexisting Conditions:**

Any problems or concerns that Rich needs to know about? _____
_____
_____
How long have you had this condition?_____Have you had this or similar conditions in the past?_____ What activities aggravate the condition?_____
Is this condition getting progressively worse? [ ] YES [ ] NO [ ] Constant [ ] Comes and Goes
Is this condition interfering with your: [ ] Work [ ] Sleep [ ] Daily Routine [ ] Other: _____
How long has it been since you really felt good? _____
List previous diagnosis and treatments you have received for your present condition:_____
_____
What do you believe is wrong with you?_____

**Family Health Information:**

| **Relation** | **Past/Present Health Problems** |
|---|---|

**HAVE YOU EVER:** DESCRIBE BRIEFLY
Been knocked unconscious? [ ] Y [ ] N _____
Used a cane, crutch, or other supports? [ ] Y [ ] N _____
Been treated for a spine or nerve disorder? [ ] Y [ ] N _____
Had a fractured bone? [ ] Y [ ] N _____
Been hospitalized other than for surgery? [ ] Y [ ] N _____

**DO YOU:** 

Take supplements, vitamins, or minerals? [ ] Y [ ] N _____
Need help with your supplements? [ ] Y [ ] N _____
Have an allergy to any drug? [ ] Y [ ] N _____
In regard to your weight, are you: [ ] Content [ ] Want to lose [ ] Want to gain
How much do you exercise per week? [ ] 0-2 hours [ ] 3-4 hours [ ] 4 or more hours

| **DATE OF LAST:** | **Less than 6 months** | **6-18 Months** | **Over 18 Months** | **Never** |
|---|---|---|---|---|
| Spinal Examination | [ ] | [ ] | [ ] | [ ] |
| Spinal X-Ray | [ ] | [ ] | [ ] | [ ] |
| Physical Examination | [ ] | [ ] | [ ] | [ ] |
| Blood Test | [ ] | [ ] | [ ] | [ ] |
| Chest X-Ray | [ ] | [ ] | [ ] | [ ] |
| Dental X-Ray | [ ] | [ ] | [ ] | [ ] |
| Urine Test | [ ] | [ ] | [ ] | [ ] |

| **HABITS:** | **Heavy** | **Moderate** | **Light** | **None** |
|---|---|---|---|---|
| Alcohol | [ ] | [ ] | [ ] | [ ] |
| Coffee | [ ] | [ ] | [ ] | [ ] |
| Tobacco Sugar/Carbs. load | [ ] | [ ] | [ ] | [ ] |
| Drugs | [ ] | [ ] | [ ] | [ ] |
| Sleep | [ ] | [ ] | [ ] | [ ] |
| Appetite | [ ] | [ ] | [ ] | [ ] |

Please list all conditions for which you have been treated in the past 10 years:

_____
_____
_____

**Primary Care Physician:**
Name:_____ Phone Number:_____
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**For Rich Pollock Assessment Use:**
Rotary Cuffs: _____
Back:_____
Knees: _____
Assessment: _____
Blood Pressure: _____ Resting Heart Rate: _____
Sit-ups:_____ Pushups: _____ Flexibility: _____
Fitness Level: 1 2 3 4 5 6 7 8 9 10