CLIENT HEALTH HISTORY

Name:_____Date:_____

To insure you receive a complete and thorough evaluation, please provide us with important background information on the following form. If you do not understand the question or require assistance, please speak with your trainer/therapist. Thank you.

GENERAL HEALTH

How would you rate your general health?

O Excellent O Good O Average O Fair O Poor

Do you smoke: O Yes, ___packs/day O No O Quit

What is your stress level? O Low O Medium O High

How many hours of sleep do you get per night?_____

EXERCISE

How often do you climb/train per week?

O none O < 1x/wk O 1-2x/wk O 3-5x/wk O 6-7x/wk

Do you climb less than you would like? Yes / No

If yes, why? O Illness O Injury O Time O Other

What style(s) of climbing do you participate in?

O Trad Climbing O Mountaineering
O Sport Climbing O Top Rope Climbing
O Bouldering O Free Soloing
O Sport Climbing O other:_____

How long have you been climbing?_____

Have you had any injuries from climbing in the past? Y / N

If yes, please describe: _____

_____

_____

Describe your typical gym session: _____

_____

_____

Describe your typical outdoor session: _____

_____

_____

What kind of equipment do you have access to?

O Full Climbing Gym Access O Rock Rings
O Hangboard O Campus Board
O Free Weights/Kettlebell O Moon Board
O None/Other:_____

What other physical activities interest you?_____

_____

MEDICATION

Please list all medications (prescription and over-the-counter) you are currently taking:_____

_____

WORK HISTORY

Occupation:_____

Work Status: O Unemployed O Student
O Full-time O Homemaker O Retired
O Part-time O Modified duty

Physical activities at work (check all that apply):

O sitting O lifting – heavy / repetitive
O standing O heavy equipment operation
O phone use O driving
O computer use O climbing
O other:_____

MEDICAL HISTORY

Have you ever had/been diagnosed with any of the following conditions? (Check all that apply)

O Cancer O Heart problems
O Depression O High blood pressure
O Stroke O Lung problems
O Kidney problems O Blood disorders
O Thyroid problems O Epilepsy / seizures
O Diabetes O Allergies
O Head injury O Arthritis – osteo
O Rheumatoid arthritis O Broken bone
O Stomach problems O Poor circulation
O Swelling O Pregnancy
O Other:_____

Please list any recent/relevant past surgeries:_____

_____

_____

GOALS

What are your reasons for coming to see us?

O Injury Prevention O Develop muscle
O Rehabilitate an injury O Improve Balance
O Improve flexibility O Nutritional Education
O Train for a Specific Event O Motivation
O Other:_____

Please list any specific goals you would like to address.

_____

_____