PAST MEDICAL HISTORY FORM

CLIENT INFORMATION:

Client Name: ____ **Date:** ____________________
Age: ____________________ **Date of Birth:** ___________________ **Marital Status:** __________
Children (Ages): ______________________________ **Spouse's Name:** ______________________________

Occupation: ____ **Employer:** __________________________
Working: Full Duty _____ **Light Duty** _____ **Part Time** _____ **None** _____
Physical Work: Heavy: _____ **Moderate:** _____ **Light:** _____ **Hours per day:** __________
Job Requirements: ____

INJURY SCREENING:

1. **Have you had any previous injuries? (Please List /Give Dates)** ____
   ____

2. **Check which apply : Work Related Injury** _____ **Motor Vehicle Accident** _____ **Other** _____
   Reoccurrence of Previous Injury _____ **Injury Related to Lifting** _____ **Athletic / Recreational Injury** _____

3. **Have you received any Special Tests: X-Ray** _____ **CAT Scan** _____ **MRI** _____ **EMG** _____ **Other** _____
   Results or Findings: ____
   ____

4. **Have you had a related surgery?** ____

HEALTH SCREENING:

Do you have, or have you had any of the following:

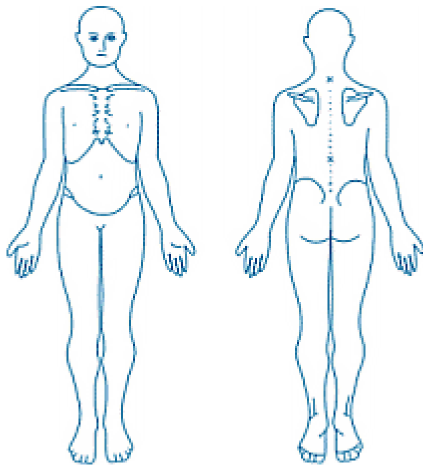
Diabetes	**No** _____	**Yes** _____	**Rheumatoid Arthritis**	**No** _____	**Yes** _____
Chest Pain / Angina	**No** _____	**Yes** _____	**Osteoporosis**	**No** _____	**Yes** _____
High Blood Pressure	**No** _____	**Yes** _____	**Allergies**	**No** _____	**Yes** _____
Myocardial Infarction	**No** _____	**Yes** _____	**Scoliosis**	**No** _____	**Yes** _____
Heart Disease	**No** _____	**Yes** _____	**Joint Disease**	**No** _____	**Yes** _____
Heart Palpitations	**No** _____	**Yes** _____	**Previous Fractures**	**No** _____	**Yes** _____
Pacemaker	**No** _____	**Yes** _____	**Jaw / TMJ Problems**	**No** _____	**Yes** _____
Headaches	**No** _____	**Yes** _____	**Nerve Injury**	**No** _____	**Yes** _____
Stroke (CVA)	**No** _____	**Yes** _____	**Thyroid Problems**	**No** _____	**Yes** _____
Poor Circulation	**No** _____	**Yes** _____	**Epilepsy or Seizures**	**No** _____	**Yes** _____
Dizziness	**No** _____	**Yes** _____	**Cancer**	**No** _____	**Yes** _____
Anemia	**No** _____	**Yes** _____	**COPD**	**No** _____	**Yes** _____
High Cholesterol	**No** _____	**Yes** _____	**Emphysema**	**No** _____	**Yes** _____
Phlebitis	**No** _____	**Yes** _____	**Asthma**	**No** _____	**Yes** _____
Hypoglycemia	**No** _____	**Yes** _____	**Shortness of Breath**	**No** _____	**Yes** _____
Lyme Disease	**No** _____	**Yes** _____	**Concussion**	**No** _____	**Yes** _____
Kidney Disease	**No** _____	**Yes** _____	**Multiple Sclerosis**	**No** _____	**Yes** _____
Bowel / Bladder	**No** _____	**Yes** _____	**Ringing in Ears**	**No** _____	**Yes** _____
Sexual Dysfunction	**No** _____	**Yes** _____	**Skin Abnormalities**	**No** _____	**Yes** _____
Metal Implants	**No** _____	**Yes** _____	**Other:** ___________	**No** _____	**Yes** _____

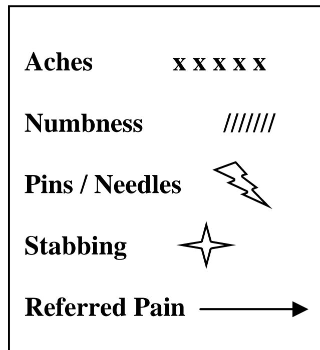
If "yes" on any of the above, please briefly explain and give approximate dates: ______________________________
____
____

GENERAL HEALTH QUESTIONS:

1. Is there a possibility you are pregnant? No _____ Yes _____
2. Do you smoke? No _____ Yes _____ If yes, packs per day: _____________
3. Do you drink alcohol? No _____ Yes _____ If yes, explain: ____
4. Do you have special diet guidelines? No _____ Yes _____ If yes, explain: _______________________________
5. Do you participate in any sports, exercise programs, or activities on a regular basis? No _____ Yes _____
   If yes, explain: ____
6. Are you presently taking any medication? No _____ Yes _____ Please list dosage, frequency, and reason for use: ____
7. Is there any other information regarding your past medical history that your trainer should know about? Please explain: ____

Please indicate below where your pain and other complaints are located:





RELATED QUESTIONS: (Answer if known)

1. Current Height: __________ Current Weight: __________ Recently Lost or Gained Weight: ___________
2. Blood Pressure: _______________ Resting Pulse (Heart Rate): _______________
3. Cholesterol Level: ____________________
4. What are your major fitness goals? ____
5. What else would you like to achieve at Game Shape?____
   ____

EMERGENCY CONTACT INFORMATION:

In the rare instance of an emergency, who should we contact?

1. Name: ____ Phone: _________________________
   Relationship to You: ____

2. Name: ____ Phone: _________________________
   Relationship to You: ____

Client Name: ____ Date: ____________________

Reviewed by Personal Trainer: ____ Date: ___________________

455 Route 9 South
Manalapan, New Jersey 07726
(732) 972 - 7555
Fax: (732) 972-5458

Welcome to Game Shape!
Please tell us how we can help you...

Let's start with the basics!

Full Name: ______________________________ **Age:** _______ **Date of Birth:** __________
Address: ______________________________
City: ______________________ **State:** __________ **Zip:** ______________
Home Phone: ____________________ **Work Phone:** ____________________
Cell Phone: ____________________ **E-Mail:** ____________________

Marital Status: ______________ **Spouse's Name:** ______________________
Children (List Names and Ages): ______________________________
Employer: ______________________ **Occupation:** ______________________

Referred by: Newspaper ______ Yellow Pages ______ Shopping Guide ______ Movie Ad _______
Brochure ______ Lead Box ______ Direct Mail ______ Physician ______ Insurance Co. ______
Patient _______ Friend ______ Family ______ Member ______ Other: ______________

Referral Source Name: ______________________________
Address: ______________________________ **Phone:** ______________

Name of Responsible Party (if different than member): ______________________
Address: ______________________________
Home Phone: ____________________ **Work Phone:** ____________________
Cell Phone: ____________________ **E-Mail:** ____________________
Date of Birth: __________________ **Employer:** ______________________

Emergency Contact: ______________________________ **Phone:** ______________

What are your health and fitness goals?

What are your fitness goals?

- □ Fat Loss
- □ Muscle Gain
- □ Shaping & Toning
- □ Strength Increase
- □ Athletic Performance
- □ Build Stamina
- □ Rehabilitate An Injury
- □ Other: _______________

What are your health goals?

- □ Improve Energy
- □ Control Stress
- □ Sleep Better
- □ Longevity
- □ Prevent Medical Problems
- □ Just Following Doctor's Advice
- □ Other: _________________

Game Shape
Physical Therapy & Sports Performance Center

455 Route 9 South
Manalapan, New Jersey 07726
(732) 972 - 7555
Fax: (732) 972-5458

Help Us To Understand What's Important To You ...

What is your health and fitness history?

Have you belonged to a gym before?	□ Yes	□ No
Have you had a personal trainer before?	□ Yes	□ No
Have you been on a fitness regime you did not stick with?	□ Yes	□ No
Have you been on a popular "diet" plan that proved unsuccessful?	□ Yes	□ No

What are your preferences?

When are you most likely to use the facility: **Early Morning** (5am - 10am) **Mid-Day** (11am - 5pm) **Evenings** (6pm - 10pm)

What is your favorite...
Drink? ______________________
Small Food Item? __________________
Fruit? __________________________

What element of our facility is most important to you? ____

Would you like help with...

Meal Planning	□ Yes	□ No
Stress Management	□ Yes	□ No
Life / Behavior Modification	□ Yes	□ No
Workout Routines	□ Yes	□ No

How else can we help you? ____

FOR OFFICE USE ONLY:

Guest Card Number: ____________________ Member Number: _____________________

Information taken by: ______________________ Date: _____________ Time: _________

Appointment for Wellness Consult: Date: ______________ Time: __________ Trainer: ___________________

GAME SHAPE GUEST CARD No. _______

Please take a moment to answer the following questions: Date:_______________________

Name____

Address____

City__________________________ State_________________ Zip________________

Phone (Home)________________________ Phone (Cell)__________________________

Email Address ____

Check below the areas that you are interested in:

Weight Loss___ Toning ___ Stress Mgmt.___ Strength Training ___ Personal Training ___
Nutrition Counseling ___ Massage Therapy___ Injury Rehabilitation___ Flexibility___
Cardiovascular Conditioning ___ Agility & Speed Training ___

How did you hear about the club? Please be specific. (Source)_________________________

I understand that I will exercise at my own risk and will hold Game Shape, LLC harmless from any claim resulting from injury or accident while using these facilities.

SIGNATURE____

Employee Init_____ Assigned Member No. ____________

455 Route 9 South
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Phone: (732) 972 -7555
Physical Therapy: (732) 617 -8090
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www.GameShapeOnline.com

NEWSLETTER OPT-IN AGREEMENT

Thank you for choosing Game Shape – Physical Therapy & Sports Performance Center. We have created a unique newsletter for you. Each month you will be provided valuable information about services, injury prevention & rehabilitation and the latest on fitness and personal training.

We will include information about special programs, giveaways and downloads. Learn about treatments, medical conditions, sports training, fitness, training techniques and more.

Information: **Please Print Clearly!**

Name: ____

E-Mail Address: ____

By submitting this information, I confirm that I am only acting for my own e-mail account, or one for which I have express authority to submit this request. Once the subscription is confirmed, I agree to accept newsletter e-mails from Game Shape – Physical Therapy & Sports Performance Center and my e-mail address will not be used for any other purpose. I understand that I may unsubscribe at any time by following your instructions and that I may still receive a limited number of e-mails while this request is processed.

Signature:_____________________________________

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