Client Intake Form

Please print clearly.

Name:	Date of Birth:	Age:
Address:		
City, State, Zip:		
Home Phone:	Work Phone:	
Employer:	Occupation:	

Please answer the following questions (circle one):

Has a doctor diagnosed you with a heart condition?	Yes	No
Have you ever had angina pectoris, sharp pain, or heavy pressure in your chest as a result of exercise, walking, or other physical activity such as climbing stairs? *(Not including the normal out of breath feeling that results from normal activity)*	Yes	No
Do you experience any sharp pain or extreme tightness in your chest in cold temperatures?	Yes	No
Have you ever experienced rapid heart beat or palpitations?	Yes	No
Have you ever had a real or suspected heart attack, coronary occlusion, myocardial infarction, coronary insufficiency, or thrombosis?	Yes	No
Have you ever had rheumatic fever?	Yes	No
Do you have or have you had diabetes, hypertension, or high blood pressure?	Yes	No
Does anyone in your family have diabetes, hypertension, or high blood pressure?	Yes	No
Has any blood relative (parent, sibling, first cousin) had a heart attack or coronary artery disease before the age of 60?	Yes	No
Have you ever or do you take medications or been on a special diet to lower your cholesterol?	Yes	No
Have you ever taken digitalis, quinine, or any other drug for your heart?	Yes	No
Have you ever taken nitroglycerine or any other tablets for chest pain?	Yes	No
Are you overweight?	Yes	No
Are you under excessive stress?	Yes	No
Do you drink heavily?	Yes	No
Do you smoke tobacco?	Yes	No
Do you have a physical condition, impairment or disability, including a joint or muscle problem, that should be considered before you begin a nutrition program?	Yes	No
Are you over 65 years old?	Yes	No
Are you over 35 years old?	Yes	No
Do you exercise fewer than three times per week?	Yes	No