Initial Assessment

PERSONAL INFORMATION		
Last Name:	First Name:	
Diagnosis:	DOB:	Sex: ☐M ☐ F
Street Address:		
City:	State:	ZIP Code:
Email:		
Home Phone:	Cell Phone:	
Parent/Guardian Name:	Parent/Guardian Cell Phone	
Emergency Contact: Relationship:	Emergency Contact Phone:	
Referred By:		

MEDICAL INFORMATION
Is your child currently seeing a PT/OT, ABA therapist, or speech therapist? Yes☐ No☐ **Please list all therapists' names and contact information.** *We will not contact them without your consent.*

Please list any medical conditions or surgeries:	
Date	**Medical Condition/Surgery**

Please check if you have any of the following:

Heart Disease☐
Diabetes☐
Renal disease☐
Stroke☐
Asthma☐
High cholesterol☐
Obesity☐
Thyroid problems☐
GI issues☐
Seizures☐
Osteoporosis☐
Hypertension☐
Back pain/injury☐
Anemia☐

Cardiac Profile:

Has your doctor every said you have a heart condition? Yes☐ No☐

Do you feel pain in your chest when you do physical activity? Yes☐ No☐

In the past month, have you had chest pain when NOT doing physical activity? Yes☐ No☐

Physical limitations

Do you have any physical problems (back, knee, hip, etc) that may inhibit your ability to work out or that could be made worse through physical activity? Yes☐ No☐

If yes, explain:

Do you have any allergies: Yes☐ No☐

Please list:

Please list all medications and supplements you are taking:		
Medication	**Dose**	**Frequency**

WEIGHT HISTORY/FITNESS LEVEL

Ht:	**Wt:**
Have you trained in a gym before? **Yes☐ No☐**	**Have you worked with a trainer before?** **Yes☐ No☐**

Current Fitness Level - 1 to 10 (10 very active)

Do you exercise: Yes☐ No☐

If yes, describe your exercise routine:

How many days per week?

How many minutes per session?

What are your current health and fitness goals? Check all that apply

Build Muscle☐ **Fun Workout☐** **Improve Performance☐**
Body-Fat Loss☐ **Improve Cardio Fitness☐** **Increase Energy Levels☐**
Create Consistency☐ **Improve Flexibility☐**
Decrease Stress Levels☐ **Improve Mood/Feel Better☐**

Others?:

How often would you like to see a trainer to help you achieve your goals?

What days of the week are best for you to commit to an exercise program?
What is the best time of day for you to exercise?
BEHAVIORS
Are there any behavior issues we should be aware of?
Are there any sensory issues we should know about?
How many hours of sleep do you get? What time do you go to bed?
What fluids do you drink a day and how much?
What activities are you presently involved in?
What is an appropriate reward for your child?
What motivates your child?
What songs and games does your child like?

Please list any other information you would like us to know:

PLAN/NOTES