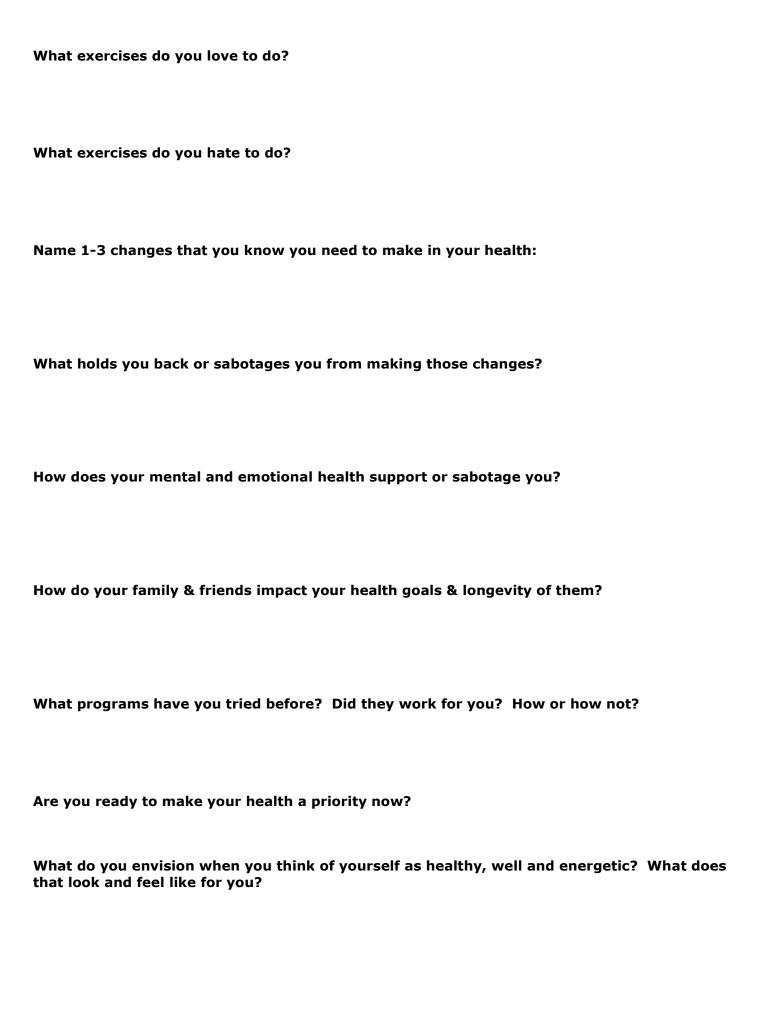
Client Intake Form

Personal Training

What are a few of the main concerns you have regarding your nutritional health and body currently?
Please share what a day in your life looks like in terms of what you eat, drink, exercise, work and sleep schedule. (This gives us a way to walk in your shoes and understand how your day impacts your life and health.)
What medications do you currently take?
What vitamins, minerals, and/or supplements do you currently take?
Do you smoke?
What injuries, surgeries or health conditions have you had or do you have that impact your life currently?
Do you have any food, supplement or environmental allergies?
On a scale of 1-10, 1 being the lowest measure, how healthy & energetic do you feel?
What foods do you love?
What foods do you hate?



How can we best support you?