



IMC New Client Intake Form

Welcome! IMC is dedicated to offering our clients quality instruction and education that helps restore the body's intrinsic strengths and capacity for fluid, natural, pain free movement. To better serve you, we ask that you please take a few minutes to complete this form. Thank you.

Name _____ Date _____

Birth date _____ Weight _____ Height _____

Occupation _____

Street address _____

City _____ State _____ Zip/Postal Code _____

Phone _____ Email _____

1. Medical History. Please check all that apply.

___ Currently under a doctor's care. If yes, please explain. _____

___ High blood pressure

___ High cholesterol

___ Diabetes

___ Known heart disease

___ A heart murmur

___ Chest pain during physical activity

___ Irregular heart beat or palpitations

___ Lightheadedness or fainting spells

___ Pain associated with menstrual cycle

___ Menstrual cramps

___ Unusual shortness of breath or _____ Asthma

___ Cramping pains in legs or feet

___ Stroke

___ Cancer

___ Emphysema

___ Thyroid or kidney disorder

___ Epilepsy

___ Hay fever or allergies

2. Date of last physical exam? _____

3. Have you recently been hospitalized? If yes, please explain. _____

4. Do you have a parent, grandparent, or sibling who, prior to age 55 has had:

___ A heart attack

___ A stroke

___ High blood pressure

___ High cholesterol

___ Weight (obesity) problems?

5. Please list any medications you currently take on a regular basis. Include any vitamins or supplements.

6. Do you exercise on a regular basis? Please list all current and any meaningful previous activities.

7. Describe your present physical condition: ___Poor ___Fair ___Good ___Excellent

8. Please describe your current nutritional habits: ___Unhealthy ___Erratic ___Healthy

9. Do you recognize how your current postural habits and/or activities might affect the pain you are experiencing? ___Yes ___No If yes, please explain.

10. Describe your physical history. Please include any ankle, knee, hip, back, shoulder, neck or any other joint pain. Please specify which areas of your body were affected. Please also include any surgeries.

11. Are you currently pregnant? _____ Previous pregnancies? _____

12. What specific fitness or health goals do you hope to achieve at IMC?

13. How did you find out about IMC? Referred by?

To the best of my knowledge, all of the above statements are complete and true.

Signature _____