POTENTRx
805 Madison Street, Suite 400
Seattle, WA 98104
(206) 432-9436 Fax: (206)432-9438

Name ____

Current Address ____

City ______________________________State _____ Zip Code ___________________

Phone Number (____)_______-___________ Cell Number (____) ________-____________

Birth Date___/____/________ Email Address _________________________________

Physician's Name____

Physician's Address____

Date of Last Physical Exam ___/____/_________ Reason for last medical visit _______________

MEDICATIONS: (Include over the counter medications you are taking currently or regularly)

Note: you may bring a computer printout if preferred

Name	Dosage	Purpose	How Long?

Allergies:

____

____

Known Diagnosis/Health Concerns

Do you have any of the following? Please check all that apply.

CONSTITUTIONAL SYMPTOMS

- ☐ Loss of appetite
- ☐ Fatigue
- ☐ Weight loss
- ☐ Weight gain
- ☐ Obesity
- ☐ Anorexia/ Bulimia
- ☐ Anemia

RESPIRATORY

- ☐ Asthma
- ☐ Pneumonia
- ☐ Emphysema
- ☐ Cough
- ☐ Shortness of breath
- ☐ Tuberculosis
- ☐ Smoker

MUSCOLOSKELETAL

- ☐ Arthritis
- ☐ Rheumatic fever
- ☐ Joint pain
- ☐ Back problems
- ☐ Broken bones
- ☐ Limited movement

CARDIOVASCULAR

- ☐ Pacemaker
- ☐ Palpitations
- ☐ Heart murmur
- ☐ Heart attack
- ☐ Chest pain/ pressure
- ☐ High blood pressure
- ☐ Elevated cholesterol
- ☐ Stent/ Bypass surgery
- ☐ Congestive heart failure
- ☐ Circulatory problems
- ☐ Claudication

NEUROLOGICAL

- ☐ Seizures
- ☐ Multiple Sclerosis
- ☐ Migraine headaches
- ☐ Fainting spells
- ☐ Dizziness
- ☐ Stroke/ TIA

ENDOCRINE

- ☐ Diabetes
- ☐ Thyroid disease
- ☐ Hot/cold all the time

PSYCHOLOGICAL

- ☐ Anxiety
- ☐ Depression
- ☐ Stress
- ☐ Sleep disorder
- ☐ Chemical addiction

CANCER HISTORY

- ☐ Yes ☐ No
- ☐ Type: _______________
- ☐ Radiation
- ☐ Chemo

FURTHER SYSTEM REVIEW:

VISION:	☐ Yes	☐ No	Comments: ____________________
AUDITORY:	☐ Yes	☐ No	Comments: ____________________
GASTROINTESTINAL:	☐ Yes	☐ No	Comments: ____________________
GENITOURINARY:	☐ Yes	☐ No	Comments: ____________________
SKIN:	☐ Yes	☐ No	Comments: ____________________
ALLERGIC/ IMMUNOLOGIC:	☐ Yes	☐ No	Comments: ____________________
HEMATOLOGIC/ LYMPHATIC:	☐ Yes	☐ No	Comments: ____________________

List past surgeries and/or procedures: ____

____

List recent injury or illness: ____

____

MUSCULOSKELETAL DETAILS

Please check any current problems/chronic conditions or past orthopedic surgeries:

☐ **Neck**	☐ **Shoulder/ Clavicle**	☐ **Pelvis**	☐ **Lower Leg**
☐ **Ribs/ Chest**	☐ **Arm/ Elbow**	☐ **Thigh/ Hips**	☐ **Ankle**
☐ **Spine**	☐ **Wrist/ Hand**	☐ **Knee/ Patella**	☐ **Foot/ Toes**

If you have checked any of the above, please explain below:

____

____

Please assist us in developing your individualized exercise plan and answer the following questions:

1. **What do you hope to gain from our program?**

2. **What is/are your overall wellness goal(s)? (Make these as specific as possible. For example don't say "weight management," say "I would like to gain/lose ___ lbs of muscle/fat")**

   a. ____

   b. ____

   c. ____

3. **What is your work week like (travel schedules, commuting, etc.)?**

4. **How do you fit exercise into your lifestyle? In the last 2 months, how many hours did you spend exercising per week?**

5. **If you exercise, how intense is it, and how long do you sustain this intensity? Include heart rate (HR) if known.**

Intensity	Mins.	HR
□ **Light** – easy walking, with no incline	_____	_____
□ **Moderate** – brisk walk, light jog	_____	_____
□ **Hard (Vigorous)** – sustainable jog (somewhat difficult)	_____	_____
□ **Very Hard** – Near maximal effort	_____	_____

6. **How active are you on most days?**
   - □ **Sedentary** (mostly sitting or standing i.e. desk job)
   - □ **Moderately active** (walking or light work some of the time i.e. cashier)
   - □ **Active** (walking, light/moderate work i.e. mail carrier)
   - □ **Very active** (walking more than half of the time, heavy work, i.e. construction worker)

7. **Please check all activities that interest you:**

☐ **Walking**	☐ **Weight Training**	☐ **Biking**	☐ **Golf**
☐ **Running**	☐ **Circuit Training**	☐ **Dancing**	☐ **Pilates**
☐ **Hiking**	☐ **Swimming**	☐ **Tennis**	☐ **Yoga**
☐ **Rowing**	☐ **Skiing**	☐ **Other:** ____________________________	

8. **What have you done in the past to promote personal fitness?**

9. **What limitations or challenges prevent you from improving/maintaining your health/fitness?**

10. **How many days per week are you willing to commit to exercise? How many minutes per day?**

11. **Do you have a membership/access to an exercise facility? Do you have any home exercise equipment?**

12. **Rank your weight lifting experience from 0-10 (0 = no experience 5 = proficient in basic lifts 10 = expert)**

    0 1 2 3 4 5 6 7 8 9 10

13. **Please list any other comments or concerns:**