



**Please note: We must receive your completed paperwork at least 1 day prior to your first session. Please fax your paperwork to 206 284 7243. Thank You!**

Name \_\_\_\_\_ Date \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ Apt # \_\_\_\_\_

City / State / Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell \_\_\_\_\_ Business \_\_\_\_\_

Email \_\_\_\_\_

Would you like to receive occasional newsletters and specials via email? Y / N

Referred By \_\_\_\_\_

**Emergency Contact**

**Name** \_\_\_\_\_ **Relation** \_\_\_\_\_

**Home Phone** \_\_\_\_\_ **Cell** \_\_\_\_\_ **Business** \_\_\_\_\_

If I am not able to make a scheduled appointment, I agree to cancel the appointment 24 hours in advance by phone, unless I have an emergency. In case of an emergency, I will call ASAP to reschedule my appointment. \_\_\_\_\_  
Initial

If I miss a scheduled appointment without giving 24 hours' notice, I agree to pay any missed appointment charge applicable. \_\_\_\_\_  
Initial

I HEREBY RELEASE STUDIO 122, LLC AND IT'S OWNERS, EMPLOYEES, AGENTS, AND ASSIGNS FROM ANY AND ALL LIABILITY FOR DAMAGE OR INJURY TO ME, ACCEPTING MYSELF THE FULL RESPONSIBILITY FOR ANY AND ALL SUCH DAMAGE OR INJURY FROM ANYONE ACTING ON BEHALF OF STUDIO 122, LLC OR ANYONE ENGAGING IN ACTIVITIES THROUGH STUDIO 122, LLC. \_\_\_\_\_  
Initial

I UNDERSTAND THAT THE PRACTITIONERS AT STUDIO 122 DO NOT DIAGNOSE ILLNESS, DISEASE OR ANY PHYSICAL OR MENTAL DISORDER; NOR DO THEY PRESCRIBE MEDICAL TREATMENT. I ACKNOWLEDGE THAT THE SERVICES AT STUDIO 122 ARE NOT A SUBSTITUTE FOR MEDICAL EXAMINATIONS OR DIAGNOSIS, AND THAT IT IS RECOMMENDED THAT I SEE A PRIMARY HEALTH CARE PROVIDER FOR THAT SERVICE. \_\_\_\_\_  
Initial

May we contact your healthcare provider? Y / N If yes, please provide info below.

Name \_\_\_\_\_ Phone # \_\_\_\_\_

Type of Practice \_\_\_\_\_

Name \_\_\_\_\_ Phone # \_\_\_\_\_

Type of Practice \_\_\_\_\_

Client Name PLEASE PRINT

Client Signature Required / Date

Signature of Parent or Guardian / Date

Please answer all questions frankly, to the best of your knowledge. All information is confidential.

Name \_\_\_\_\_ Date \_\_\_\_\_

Weight \_\_\_\_\_ Height \_\_\_\_\_ Blood Pressure (if known) \_\_\_\_\_ / \_\_\_\_\_ % Body Fat (if known) \_\_\_\_\_

1. Are you presently taking any medications, nutritional supplements or vitamins? Please list

\_\_\_\_\_

\_\_\_\_\_

2. Do you presently, or have you ever had, any of the following conditions? Please circle

Anemia

Diabetes

Liver Problems

Arthritis

Frequent Headaches

Lymphoedema

Asthma

Heartburn

Osteoporosis

Cancer

Heart Disease

Sinus Infections (chronic)

Chest Pains

High Blood Pressure

Skin Conditions

Cold/Flu symptoms (chronic)

High Cholesterol

Thyroid Conditions

Chronic Fatigue

Hypoglycemia

Unexplained Weight Gain/Loss

Depression

Kidney Problems

Varicose Veins

Please explain: \_\_\_\_\_

\_\_\_\_\_

3. Please list any surgeries, starting with the most recent: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

4. Hospitalizations: \_\_\_\_\_

\_\_\_\_\_

5. How much sleep do you get each night on average? \_\_\_\_\_

6. What would you consider the quality of your sleep? \_\_\_\_\_

\_\_\_\_\_

7. Do you smoke, drink alcohol or use recreational drugs? \_\_\_\_\_

How much, how often? \_\_\_\_\_

8. How often do you drink caffeinated beverages? \_\_\_\_\_

9. How much water do you drink daily? \_\_\_\_\_

10. Do you have any food allergies, sensitivities or restrictions? \_\_\_\_\_

\_\_\_\_\_

11. Please list foods that you tend to overeat or crave (sweets, breads, fatty foods, meat, etc.)

\_\_\_\_\_

\_\_\_\_\_

12. Are there any foods that you eat on a daily basis, almost day basis? \_\_\_\_\_

\_\_\_\_\_

13. Do you "miss" these foods if you do not eat them?

14. Write briefly about your weight gain/loss history: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

15. What do you feel triggered your weight fluctuation? Please circle

Heredity

Stress

Eating Habits

Boredom

16. Was your weight gain/loss: Please circle

Sudden

Gradual

Problem Since Childhood

17. What methods have you tried to lose/gain weight? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

18. Please list close relatives that have diabetes, heart disease or obesity: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

19. Please answer the following questions Yes or No:

- |   |           |          |
|---|-----------|----------|
| a. If I'm feeling down, a snack makes me feel better.                   | Yes _____ | No _____ |
| b. I sometimes have a hard time going to sleep without a bedtime snack. | Yes _____ | No _____ |
| c. I get tired and/or hungry in the mid-afternoon.                      | Yes _____ | No _____ |
| d. I get sleepy after eating a meal containing bread, pasta or dessert. | Yes _____ | No _____ |
| e. Now and then I think I am a secret eater.                            | Yes _____ | No _____ |
| f. I have difficulty concentrating or frequent fuzzy/spacey thinking.   | Yes _____ | No _____ |
| g. I experience cravings for sugar, breads, pasta and baked goods.      | Yes _____ | No _____ |
| h. I feel shaky if I don't eat on time or don't snack.                  | Yes _____ | No _____ |
| i. I often find myself irritable or angry.                              | Yes _____ | No _____ |

20. How is your energy level? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

21. Are there times that you feel best? \_\_\_\_\_ Worst? \_\_\_\_\_

22. Are you happy in your life right now? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

23. What are your main sources of stress? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

24. How do you deal with your stress? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

25. In your estimation, how physically fit are you right now?

Unfit \_\_\_\_\_ Below Average \_\_\_\_\_ Average \_\_\_\_\_ Above Average \_\_\_\_\_ Very Fit \_\_\_\_\_

26. How often do you exercise? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

27. What is your regime? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

28. If you do not currently exercise, what types of exercise have you enjoyed doing in the past? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

29. What are your fitness goals? (check all that apply)

General Fitness \_\_\_\_\_

Muscle Toning \_\_\_\_\_

Weight loss / Maintain Weight \_\_\_\_\_

Muscle Strengthening \_\_\_\_\_

Osteoporosis Prevention \_\_\_\_\_

Muscular Coordination / Balance \_\_\_\_\_

Flexibility \_\_\_\_\_

Other \_\_\_\_\_

Specific Sports Enhancement \_\_\_\_\_

Sport: \_\_\_\_\_

30. Do you have any current injuries? \_\_\_\_\_

31. Do you have any past injuries? \_\_\_\_\_

32. Please indicate any areas of pain or discomfort in the diagram below

○ = chronic pain

X = acute pain

