



Nichols Performance Camp 2010

PERSONAL INFORMATION

Name: _____ DOB: _____ F M Today's Date: _____
 Address: _____ Occupation: _____
 City: _____ State: _____ Zip Code: _____ Cell Phone: _____ Home Phone: _____
 E-mail Address: _____ Emergency Contact: _____ Phone: _____
 Sports: _____ Position: _____
 School: _____ School Grade: _____ Coaches Name: _____
 Other: _____

PHYSICAL ACTIVITY and MEDICAL QUESTIONNAIRE

1. Has a doctor ever said you have a heart condition and recommended only medically supervised activity?
2. Do you have chest pain brought on by physical activity?
3. Do you tend to lose consciousness or fall as a result of dizziness?
4. Has a doctor ever recommended medication for your blood pressure or a heart condition?
5. Do you have a bone or joint problem that could be aggravated by proposed physical activity?
6. Are you aware, by your own experiences or a doctor's advice, of any physical reason against you exercising without medical supervision?
7. Are you over the age of 65 and not accustomed to vigorous exercise?
If you answered YES to any of the above, please answer the following:
8. Have you consulted your physician regarding increasing your physical activity and/or performing a fitness assessment?
9. If you answered NO to question 8, will you consult your physician prior to increasing your physical activity and/or performing a fitness assessment?

	YES	NO		YES	NO
_____	_____	_____	Heart Condition	_____	_____
_____	_____	_____	Diabetes	_____	_____
_____	_____	_____	Asthma-uncontrolled	_____	_____
_____	_____	_____	Short of Breath	_____	_____
_____	_____	_____	Arthritis Bursitis	_____	_____
_____	_____	_____	Rheumatism	_____	_____
_____	_____	_____	Hernia	_____	_____
_____	_____	_____	Recent Surgery	_____	_____
_____	_____	_____	Sacroiliac Problem	_____	_____
_____	_____	_____	Angina	_____	_____
_____	_____	_____	High Blood Pressure	_____	_____
_____	_____	_____	Knee Problems	_____	_____
_____	_____	_____	Back Problems	_____	_____
			Cervical <input type="checkbox"/> Thoracic <input type="checkbox"/> Lumbar <input type="checkbox"/>		
			<i>If YES to any of the above, please see Performance Manager before exercise is scheduled.</i>		
			Describe any musculoskeletal injuries you have: _____		

I certify that the above statements are true and correct. I understand that a Doctor's note may be requested. If a note is requested, I should not proceed with this program until the note is received.

Client Signature: _____ Date: _____

GOAL ASSESSMENT QUESTIONNAIRE

1. What is your primary athletic goal?

2. Why are your goals important to you?

3. What is your level of experience with strength and conditioning (i.e. core training, strength training, power training, speed training, RNT (plyometrics))

4. Are you willing to put forth the work ethic, commitment, and discipline required to maximize your personal and athletic potential? Yes NO
5. Have you ever worked with a sports performance trainer before?

6. Do you have a specific time frame in mind for achieving your athletic goals?

7. Notes:

