AM HEALTH & PERFORMANCE

Date:

Client Information Form

Patient Information			
☐ Dr. ☐ Mr. ☐ Mrs. ☐ Miss. ☐ Ms. ☐ Master.	Full Name:		Marital Status(Circle): *Single/Married/Divorced/Separated/Widow*
Country of Birth:	D.O.B	Age:	☐ Male ☐ Female
If patient Under 18, Name of Parent/Guardian:		Relationship:	
Home Address:			Postcode:
Phone (H)	Phone (M)	Phone (W):	
Email address:			
Emergency Contact Name:	Relationship:		Phone:
Occupation:			
Referred to AM Health & Performance by:			☐ Coach ☐ Website ☐ Family/Friend ☐ Other

Sporting Information			
Current Sport/s:	Club/Team:		
Level (Circle): *Club/State/National/International*	Sporting History:		
Purpose of Strength Consultation *(what you want to achieve)*:			
Training History:			
Current Injuries:			
Previous Injury History:			
Training Load (How much)? /Week	What Exercise?		
What are your physical stress levels like (1 minimal – 10 major/Burnout):			
Coaches Name:	Coaches Details:		