Move Method Client Intake Form

Personal Information

Full Name: _____

Date of Birth (DD/MM/YYYY): _____

Email Address: _____

Phone Number: _____

Emergency Contact Name: _____

Emergency Contact Phone: _____

Health & Medical History

Please check any that apply and provide details where necessary:

□ Heart condition or high blood pressure

□ Diabetes or metabolic disorder

□ Asthma or respiratory issues

□ Joint pain or injury (e.g., knees, hips, shoulders)

□ Recent surgery or hospitalization

□ Pregnancy or postpartum

□ Other (please specify): _____

Are you currently under the care of a physician or physical therapist?

□ Yes □ No

If yes, please describe: _____

Medications (if any):_

_____

Movement & Lifestyle

What are your primary goals with Move Method?

□ Improve mobility

□ Build strength

□ Increase energy

□ Reduce pain or stiffness

□ Support mental wellness

□ Other:

_____

How often do you currently exercise?

□ Rarely

□ 1–2x/week

□ 3–4x/week

□ 5+ times/week

Preferred session format:

□ In-person □ Virtual □ Hybrid

Do you have any movement restrictions or exercises you've been advised to avoid? □ Yes □ No
If yes, please explain: _____

P**references & Support**

What motivates you most?
□ Encouragement and accountability
□ Clear goals and structure
□ Flexibility and flow
□ Education and body awareness

How do you prefer to receive feedback?
□ Verbal cues during sessions
□ Written notes or follow-ups
□ Visual demos
□ All of the above

I, _____, am the parent/legal guardian of _____ and hereby consent to and sign this waiver on their behalf.

Signature
I confirm that the information provided above is accurate to the best of my knowledge. I understand that this form is used to support safe and effective programming and does not replace medical advice.

Signature: _____ **Date:** _____
(MM/DD/YYYY)