



2605 Thomas Drive, Suite 120, Panama City Beach, FL 32408

ACCUFIT INTAKE FORM

CLIENT INFORMATION

Name _____ Date _____

Date of Birth _____ Gender _____

Address _____

City _____ State _____ Zip Code _____

Email Address _____ Phone No _____

Emergency Contact _____ Phone No _____

How did you hear about us? _____

MEDICAL HISTORY

Please select any relevant conditions below:

- | | | |
|--|---|--|
| <input type="checkbox"/> Adrenal gland issue | <input type="checkbox"/> Gout/arthritis | <input type="checkbox"/> Liver condition |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> G6PD deficiency | <input type="checkbox"/> Low blood pressure or Fainting spells |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart condition/murmur | <input type="checkbox"/> Neuromuscular disease |
| <input type="checkbox"/> Autoimmune condition | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Respiratory condition |
| <input type="checkbox"/> Blood disorder | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Stomach/duodenum ulcer |
| <input type="checkbox"/> Digestive/pancreas issues | <input type="checkbox"/> Infective endocarditis | <input type="checkbox"/> Thyroid/Parathyroid condition |
| <input type="checkbox"/> Emphysema/COPD | <input type="checkbox"/> Infectious mononucleosis | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Epilepsy/siezures | <input type="checkbox"/> Kidney disease | |

