Sports Rehabilitation and Performance Center
Bike Fitting Services
Client Intake Form

Evaluator ____________________

Name ____ Date ____________________
Last First

Address ____
Street City State Zip

Phone No. ____________________ ____________________ ____________________
Home Work Cell

E-mail ____________________ What is your ***preferred*** contact? ❒ Home ❒ Work ❒ Cell ❒ E-mail

Emergency/Parental Contact ____
Name Relationship to Client Phone Number

Referred by ____

Date of Birth ____________________ Age __________ Sex: ❒ Male ❒ Female Height __________ Weight ________

BICYCLE BACKGROUND

Do you own a bike? ❒ NO ❒ YES

If yes: How many bikes do you own? ❒ One ❒ Two ❒Three or more

What kind of bike? ❒ Road ❒ Track ❒ Triathlon ❒ Mountain ❒ Downhill ❒ Cross ❒ Folding

❒Recumbent ❒ Commuter ❒ BMX ❒ Hybrid ❒ Other____________________

How old were you when you first learned to:

Ride a bicycle?____________ Use hand brakes?______________ Shift gears?______________

In the past year, how frequently did you ride a bike?

❒ Daily ❒ A few times a week ❒ Once a week ❒ Once every few weeks ❒ Rarely

How far do you ride? ❒ 1 to 5 miles ❒ 6-15 miles ❒ 16-30 miles ❒31-50 miles ❒ 51+ miles

What is your average speed and cadence? ____

Are you competing? ❒ NO ❒ YES

If yes, do you have a racing license? ❒ NO ❒ YES If yes, in which categories?____________________

Describe the type of riding you do most frequently ________________________________

BIKE FITTING

Have you ever had a bike fitting? ❒ NO ❒ YES If yes, how long did it take?____________________

What was the primary purpose for the bike fitting?

❒ To fit for a new bike ❒ To improve the fit of an existing bike ❒ To accommodate for injury/pain

What prompted you to previously get a bike fit?____________________________________

Did you follow up with the bike fitter after riding your bicycle? ❒ NO ❒ YES

HISTORY

Are you currently comfortable on the bike you ride most frequently? ❒ NO ❒ YES

If no, please describe why ____

This bike was purchased ❒ NEW ❒ USED from ❒ Bicycle retailer ❒ Mail order ❒ Gift/hand me down ❒ Other

Have you ever crashed a bike? ❒ NO ❒ YES If yes, how many times? _____ Date of most recent crash __________

Do you take spinning classes? ❒ NO ❒ YES If yes, how frequently? _______

Do you participate in any other type of exercise? ❒ NO ❒ YES If yes, how what type? ____________________

Do you ride/train: ❒ Solo ❒ With a group ❒ Both

Do you wear: ❒ Bicycle Helmet ❒ Cycling Gloves ❒ Bike Shorts ❒ Bike Shoes

Pedal system

What kind of pedals do you use? ____

How many gears does your bicycle have? ______________________

Cycling goals/aspirations ____

Cycling history____

____

MEDICAL HISTORY

Please indicate if you have or had any of the following illnesses or conditions. Include dates and explanations below where needed.

- ❒ Allergies (if yes, list below)
- ❒ Anemia (including sickle cell)
- ❒ Altitude sickness
- ❒ Arthritis (if yes, what type?)
- ❒ Asthma/Respiratory disorder
- ❒ Auto immune disease
- ❒ Balance issues
- ❒ Blacking out
- ❒ Blood disorder
- ❒ Broken bones/fractures
- ❒ Cancer
- ❒ Carpal tunnel
- ❒ Childbirth
- ❒ Chronic skin irritation
- ❒ Circulation/Vascular problems
- ❒ Depression/psychological disorder
- ❒ Developmental or growth problems
- ❒ Diabetes/High blood sugar
- ❒ Edema
- ❒ Epilepsy/Convulsive disorder
- ❒ Frequent/severe headaches
- ❒ Gastrointestinal/Stomach problems
- ❒ Head injury/concussion (how many)
- ❒ Hearing issues
- ❒ Hearing loss
- ❒ Heart problems
- ❒ Heat stroke/exhaustion
- ❒ Hemorrhoids
- ❒ High blood pressure
- ❒ History of fainting/dizziness
- ❒ Infections
- ❒ Joint pain (specify joint)
- ❒ Kidney/Genitourinary disorder
- ❒ Limb length discrepancy
- ❒ Loss of limb/amputation
- ❒ Lower back pain
- ❒ Low blood sugar (hypoglycemia)
- ❒ Lung problems
- ❒ Lyme disease
- ❒ Mastectomy
- ❒ Menopause
- ❒ Multiple sclerosis
- ❒ Musculoskeletal disorders
- ❒ Neck pain
- ❒ Numbness/tingling/burning in feet
- ❒ Numbness/tingling/burning in hands
- ❒ Pregnancy
- ❒ Pulmonary function
- ❒ Open wounds
- ❒ Repeated infections
- ❒ Rheumatologic disorders
- ❒ Skin diseases
- ❒ Sexual dysfunction
- ❒ Swelling of the ankles
- ❒ Thyroid problems
- ❒ Tinnitus
- ❒ Weight problem (overweight, underweight)
- ❒ Vertigo
- ❒ Vision problems
- ❒ Upper back pain

If YES to any of the above, please explain. ____

____

____

Allergies ____

____

Current medication(s) and dosage(s) ____

____

Do you take any vitamins, minerals, supplements or other non-prescription medications? ❒ NO ❒ YES
If yes, please list ____

Have you ever taken medication to improve athletic performance? Please describe ______________________

____

Have you ever been hospitalized? ❒ NO ❒ YES If yes, why? ______________________
Do you currently smoke? ❒ NO ❒ YES Have you smoked in the past? ❒ NO ❒ YES
Do you drink alcohol? ❒ NO ❒ YES If yes, how many drinks per week? ______________
Have you/are you experiencing excess fatigue/stress? ❒ NO ❒ YES
Please provide details for any major medical events not listed above (surgeries, traumas, major illnesses) ________

____

____

MEDICAL TESTS

Have you had any of the following medical tests *within the past year*?

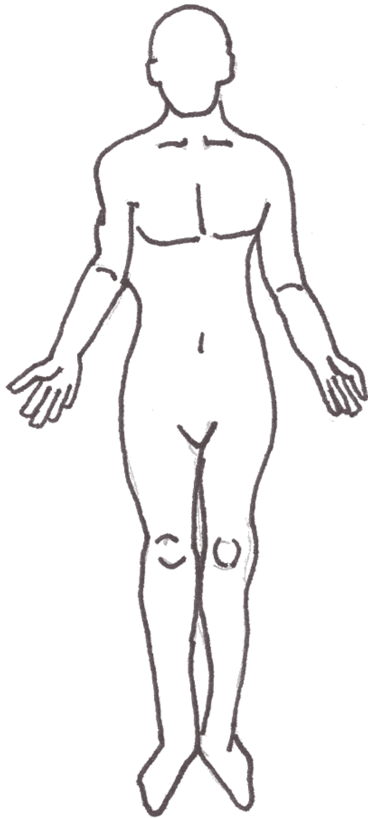
❒ Angiogram ❒ Echocardiogram ❒ Stress test
❒ Blood tests ❒ EKG (electrocardiogram) ❒ X-Rays
❒ CT Scan ❒ MRI ❒ Other ______________

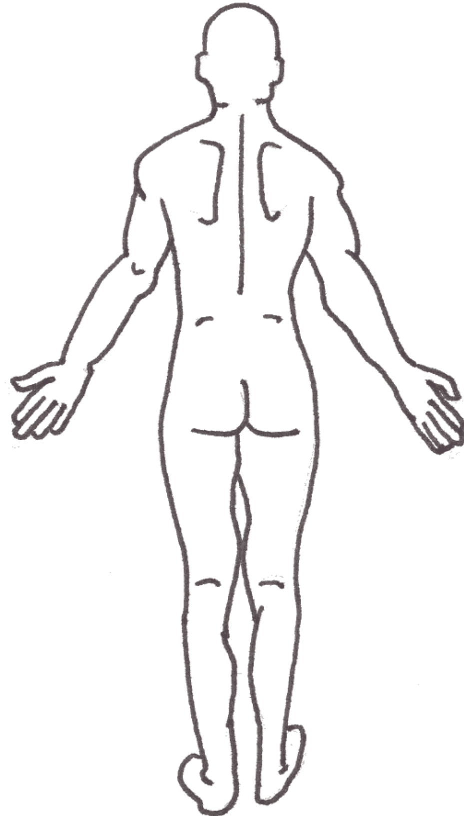
ORTHOPEDIC HISTORY

Please include any major **musculoskeletal injuries and/or surgeries** in the following areas. Please include sprains, strains, dislocations, fractures, arthritis, bursitis or tendonitis.

Area			Date	Injury Type	Outcome
Foot	❒ Right	❒ Left	______	______	______
Ankle	❒ Right	❒ Left	______	______	______
Lower Leg	❒ Right	❒ Left	______	______	______
Knee	❒ Right	❒ Left	______	______	______
Thigh	❒ Right	❒ Left	______	______	______
Hip/Pelvis	❒ Right	❒ Left	______	______	______
Spine			______	______	______
Torso			______	______	______
Shoulder	❒ Right	❒ Left	______	______	______
Upper Arm	❒ Right	❒ Left	______	______	______
Forearm	❒ Right	❒ Left	______	______	______
Wrist	❒ Right	❒ Left	______	______	______
Hand	❒ Right	❒ Left	______	______	______
Neck			______	______	______
Head			______	______	______
Other	❒ Right	❒ Left	______	______	______

BODY DIAGRAM





Are you willing to allow changes to be made to your bicycle?	❐ NO	❐ YES
Are you willing to change bars, stem, seat post, levers, saddle or pedals if recommended?	❐ NO	❐ YES
Do you understand that you are taking a risk whenever you undertake an exercise program?	❐ NO	❐ YES

I declare the above information on all four pages of this Client Intake Form to be accurate, correct, and a true reflection of my (or my minor's) physical condition.

Signature ______________________________ Date ______________________