RealRehab
SPORTS + PHYSICAL THERAPY

Metabolic Testing Request

Testing Package Requested: _____

□ Resting Metabolic Test	□ Bike MTB: ___ Thru Axle: □Y □N	□ Nutrition Consult
□ Metabolic Efficiency Test	□ Treadmill	□ Coaching Consult
□ VO2 Max test	□ Rowing Erg	□ Prior testing?
□ Race Prep	□ Other	Date: _____Type:_____

Client Information

Name: _____

Date of Birth: _____ Sex: Male: ____ Female: ____ Height: _____Weight: _____

Address: _____City:_____State:_____Zip:_____

Home Phone: _____ Work Phone: _____ E-mail address: _____

Name and Phone of Emergency Contact: _____

Please answer the following important questions as precisely as you can. Your testing specialist will review this form with you and may require further investigation to ensure your safety.

1. Occupation/tasks: _____

2. Sports/Hobbies: _____

3. Exercise level (please describe your current sport, exercise, and recreational activities and how often you participate in each):_____

_____

_____

4. What are your goals for this visit? _____

_____

5. What are your upcoming athletic goals, recreational goals, or weight management goals?

_____

_____

6. List upcoming races, if any: _____

_____

8. If you currently have a coach, please provide an email where we can send your results: _____

9. Area of concern (please describe as closely as possible any other information you think might be pertinent):

_____

_____

10. Are you interested in a Biomechanical Analysis or physical therapy consult to address concerns? _____

11. How did you hear about us?_____

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Training Information

Do you have a history of GI distress (during exercise or in general)? □ Y/ □ N, If yes, please explain: _____

Do you follow any particular method of eating/diet? Do you have dietary restrictions (medical or self-imposed)? _____

Are you trying to gain or lose weight? _____

Do you currently use supplements to fuel workouts? Describe: _____ _____

What does your training week look like now? Please provide answers where appropriate:

- For each mode of exercise: How many days per week do you train? How many weekly hours? _____
- Have you recently increased or decreased training loads? _____
- Do you follow a periodized schedule (build weeks, rest, build)? _____
- How long is your longest training session in the last 3 weeks? Duration, distance? _____ _____
- What is your average pace for endurance/steady state efforts? _____
- What is your typical race/event pace? _____
- Are you doing interval training? If so, pace for 1-3 min intervals? _____
- Do you use HR for training? Any other technology metrics? (cadence, form, run power) _____
- What is the highest HR you have noticed in the past year? _____
- Do you know your average HR for endurance efforts? _____
- Do you use a power meter on the bike? If so, do you know your FTP? _____
- Is most of your training indoors or outdoors? _____

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HEALTH HISTORY

1. Are you currently under the care of any health care provider? □Y □ N

If yes, please state type of provider and nature of condition and treatment: _____

_____

2. Do you have any condition that a doctor says may limit your exercise? □ Y □ N If Yes, Explain below:

_____

3. Have you ever smoked? □ Y □ N If Yes, when did you quit? _____

4. Have you ever been diagnosed with, or suspect that you may have/had any of the following*?

1) Heart problems/disease □Y □N
2) Stroke/CVA □Y □N
3) High/low blood pressure □Y □N
4) Anemia □Y □N
5) Respiratory /Asthma □ Y □N
6) Cancer □ Y □N
7) Bowel/bladder dysfunction □Y □N
8) Arthritic conditions □Y □N
9) Diabetes □Y □N
10) Seizures □Y □N
11) Neurological disorder(s) □Y □N
12) Other Brain injuries/disorders □Y □N
13) HIV/AIDS □Y □N
14) Eating disorder(s) □Y □N
15) Allergies □Y □N
16) Any mental illness □Y □N
17) Depression □Y □N
18) Pacemaker □Y □N
19) Orthopedic injuries □Y □N

*Please provide details on all "yes" answers to the above questions:_____

Please describe and date any surgeries, hospitalizations or other conditions or injuries you have experienced, if not already addressed:

_____

_____

Please list any prescription medications that you are taking, or have taken in the last week:

_____

_____

Please list any over-the-counter medications, vitamins and/or nutritional supplements that you are taking, or have taken in the last week: _____

By signing below I attest that all of the information that I have provided is true and accurate to the best of my knowledge.

Participant signature: _____ Date: _____

Parent/Guardian signature: _____ Date: _____