RealRehab
SPORTS + PHYSICAL THERAPY

Metabolic Testing Request

Testing Package Requested: ____

□ Resting Metabolic Test □ Metabolic Efficiency Test □ Race Prep	□ Bike MTB: ___ Thru Axle: □Y □N □ Treadmill □ Rowing Erg □ Other	□ Nutrition Consult □ Prior testing? 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: _______________