



Bike Fitting Client Information Form

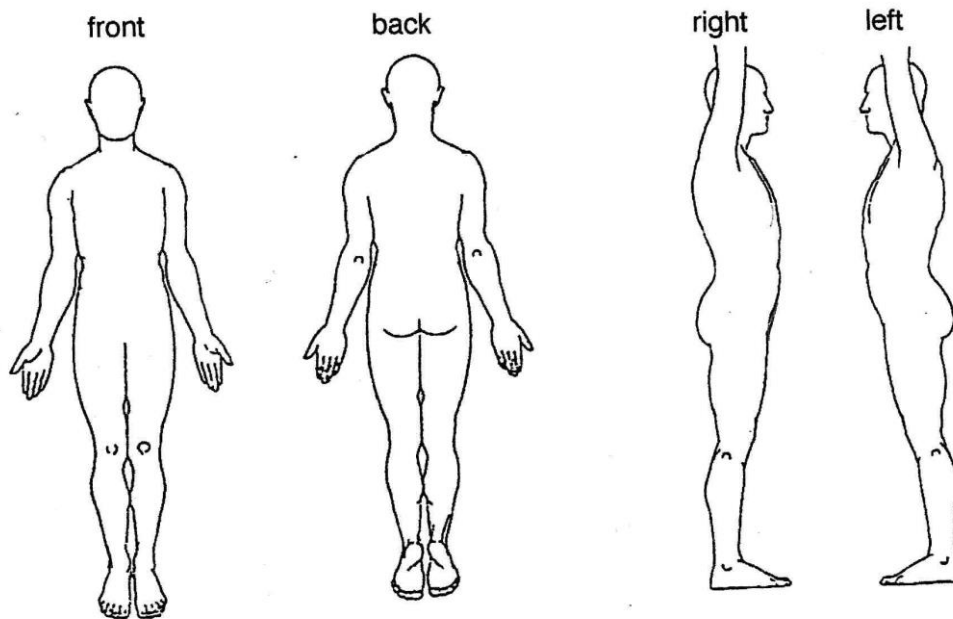
Date: _____

Name		DOB	Male / Female
Address			
City	State		Zip
Home Phone		Work Phone	
Occupation			
Referred by			
Are you under the age of 17? If yes, we must have written consent of a parent or guardian to receive a bike fitting.			

MEDICAL INFORMATION

- Yes No *Have you had a bike fitting before? If yes, how recently and with whom? _____*
- Yes No *Do you frequently suffer from stress?*
- Yes No *Do you have diabetes?*
- Yes No *Do you experience frequent headaches?*
- Yes No *Are you pregnant?*
- Yes No *Do you suffer from arthritis? Where: _____*
- Yes No *Are you wearing dentures?*
- Yes No *Do you have high blood pressure? If yes, do you take medication? Yes / No*
- Yes No *Do you suffer from epilepsy or seizures?*
- Yes No *Do you suffer from joint swelling? Where?: _____*
- Yes No *Do you have/have had any neurological disorders? If yes, please list on notes page:*
- Yes No *Do you have any contagious diseases? If yes, please list on notes page:*
- Yes No *Do you have osteoporosis?*
- Yes No *Do you have any allergies?*
- Yes No *Have you experienced stress fractures? If yes, please list on notes page:*
- Yes No *Do you bruise easily?*
- Yes No *Have you ever broken any bones, exclude fingers and toes? If yes, please list on notes page: _____*
- Yes No *Have you been in an accident or suffered injuries in the past two years? Please explain on notes page.*
- Yes No *Do you have cardiac or circulatory problems?*
- Yes No *Do you suffer from neck or back pain?*
- Yes No *Do you have numbness or stabbing pains anywhere?*
- Yes No *Do you stretch or work on range-of-motion activities? If yes, how many minutes/hours weekly? _____*
- Yes No *Any surgeries? List them on notes page: _____*
- Yes No *Do you have, or have you ever had, cancer?*
- Yes No *Do you have any other medical condition or are you taking any medications I should know about? _____*
- Yes No *Do you have tension or soreness (including sprains/strains) in a specific area? Please specify: _____*
- Yes No *Do you currently cycle? Please list frequency, and intensity: _____*

Yes No Do you have other concerns we should be aware of? Please explain on notes page:



BODY MAP

Please complete the body map using the symbols below.

O – Areas in need of extra attention (pain, tension, instability or other concern). Please make brief notes near the areas of concern.

What are your expectations and/or major goals of a bike fitting?

RELEASE

Please read carefully and sign below.

I understand that the bike fitting adjustments I receive are provided for the basic purpose of increasing function and reducing muscular tension in an effort to help with bike fitting variables. If I experience any pain or discomfort during this session, I will immediately inform the bike fitter so that the exercises/activities may be adjusted to my level of comfort. Initial:

I further understand that bike fitting services should not be construed as a substitute for a medical examination, diagnosis or treatment and that I should see a physician, chiropractor or other qualified medical specialist for any mental or physical ailment of which I am aware. I understand that bike fitters are not qualified to perform spinal or skeletal adjustments, diagnose differences in limb length, prescribe or treat any physical ailment and that nothing said in the course of the session given should be construed as such. Because bike fittings/bodywork should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep Matthew Schieferstein/Gear Up Velo updated as to any changes in my cycling comfort, medical profile and understand that there shall be no liability on the fitter's part should I fail to do so.

Client Signature: _____
Parent or Guardian Signature Needed if under the age of 17)

Date: _____

Parent or Guardian Signature: _____

Date: _____

