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Phone: 623.486.2331 Fax: 623.486.3136
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GOLF FITNESS HISTORY AND GOALS QUESTIONNAIRE

Date: _______________

Client Name: ____

Date of Birth: _____________ **Gender:** _________________

Golf Experience:

- **Are you a right or left handed golfer?** ______________________________
- **How long have you been golfing?** _________________________________
- **How many times per week do you golf?** ____________________________

Golf Concerns:

- **Do you experience pain during or after golf?** ____
- **If yes, where do you experience your pain?** ____
- **Do you feel you have any limitations or difficulties that hinder your golf game?** ________________________
- **If yes, please explain:**____

Injury/Surgery History: ____
____
____
____

What specific goals and desires do you have regarding golf and the Golf Fitness Program?

____
____
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Revised 8/24/17