Functional Movement Assessment

Client Name	
Date of Assessment	

What types of activities or exercises do you currently do? (e.g., walking, running, strength training, yoga, team sports, etc.)

Do you experience any difficulty or pain during specific movements or activities?

☐ No ☐ Yes, please detail _____

Do you have any current injuries/limitation that may affect your movement screening today?

☐ No ☐ Yes, please detail _____

Have you been diagnosed with any chronic conditions that might affect your movement (e.g., arthritis, scoliosis, etc.)?

☐ No ☐ Yes, please detail _____

Are you currently experiencing pain?

☐ No ☐ Yes, please detail _____

What are your main reasons for completing this assessment? (e.g., improve performance, manage pain, identify movement restrictions)

What activities, sports, or tasks are you hoping to improve or return to?

Is there anything else you'd like us to know about your movement, fitness, or health?