CORE EFFECTS

Personal Information

Last Name First Name

Home Phone Cell Phone DOB / /

Home Address Apt #

City State Zip Code

Email Address ☐ Male ☐ Female

Emergency Contact: Phone Number: Relation:

Health History

Do You Have:

- ☐ Asthma
- ☐ Hypertension
- ☐ Seasonal or Food Allergies
- ☐ Heart Disease
- ☐ High Cholesterol
- ☐ Sleep Apnea
- ☐ Diabetes
- ☐ Thyroid Disorder
- ☐ Cancer
- ☐ Pacemaker
- ☐ Musculoskeletal Disorder/Disease
- ☐ Arthritis
- ☐ Other:

Have you ever had:

- ☐ Heart Attack
- ☐ Chest Pain
- ☐ Stroke
- ☐ Seizures
- ☐ Chronic lower back pain
- ☐ Unusual fatigue
- ☐ Trouble Sleeping
- ☐ Surgery:
- ☐ Tendon/Ligament Injury:
- ☐ Joint Injury:
- ☐ Other:

Other:

- ☐ Are you more than 20lbs overweight?
- ☐ Do you smoke
- ☐ Are you pregnant?
- ☐ Do you take prescription medication? (Please list below)

Please list or attach record of important medical events, illnesses, diagnosis, & medications:

Date of most recent complete medical/physical examination: Are you currently cleared for physical activity? If there any reason to suspect that you may not be cleared for physical activity, please explain:

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Goals & Motivation

What are your goals for your health/fitness program? Check all that apply:

☐ Body Fat Loss
☐ Develop Muscle Tone
☐ Rehabilitate an Injury
☐ Fall Prevention/Balance Training
☐ Reduce Symptoms of Medical Illness
☐ Alleviate Pain
☐ Design a More Advanced Program
☐ Improve Confidence in the Gym
☐ Accountability
☐ Making Exercise More Fun
☐ Stress Relief
☐ Other:_____

Which areas would you like to see the most improvement? Check all that apply:

☐ Legs/ Thighs
☐ Hips/Buttocks
☐ Arms
☐ Chest
☐ Back
☐ Abdominals/ Stomach
☐ Muscular Strength
☐ Muscular Endurance
☐ Cardiovascular Endurance
☐ General Health
☐ Mood
☐ Other:_____

If any, which *Activities of Daily Living* do you have issues performing (ex. Walking up steps, getting in/out of a car)?_____

When would you like to reach your goal:_____Do you think this is a reasonable & healthy time frame? **Yes** **No**

Realistically, how many days per week do you think you need to exercise to reach your goal?_____

What do you think is the best method for you to track your progress?_____

Why is it important to reach your goals now?_____

What is preventing you from reaching your goals?_____

How would you rate your current health level? **Very healthy** **Healthy** **Somewhat Healthy** **Not Healthy**

Where do you rate healthy in your life? **Low Priority** **Medium Priority** **High Priority**

On a scale of 1-10 (10 being the highest), how committed are you to reaching your goals? **1 2 3 4 5 6 7 8 9 10**

Lifestyle

Are you a member of a gym or have access to one? **Yes** **No** Have you exercised regularly in the last 3 months? **Yes** **No**

How often do you exercise?_____

What types of exercise do you enjoy? _____

_____

If your participation is lower than you would like it to be, what are the reasons (ex: Lack of interest, Illness/Injury, Lack of time):_____

_____

_____

Which health professionals have you worked with before? Circle all that apply:

Personal Trainer **Physical Therapist** **Chiropractor** **Massage Therapist**

If applicable, please list the issues they addressed:_____

_____

_____

Describe your job/lifestyle: **Sedentary** **Somewhat Active** **Active** **Physically Demanding**

How long do you commute per day?_____ Do you travel frequently? **Yes** **No**

How many hours of sleep do you get per night:_____What time do you wake up?_____Fall Asleep?_____

On a scale of 1-10 (10 being the highest), how would you rate your stress level? **1 2 3 4 5 6 7 8 9 10**

List your 3 biggest sources of stress:_____

_____

_____

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Nutrition Habits

How many meals and snacks do you eat per day? ☐ 1-2 ☐ 3-4 ☐ 5-6

How many times per week do you eat out? ☐ 1-2 ☐ 3-4 ☐ 5-6 ☐ 7+

How often do you drink alcohol? _____

How many ounces of water do you drink daily? _____

Are you hungry between meals? **Yes** **No**

Do your energy levels drop in the afternoon? **Yes** **No**

Are you currently on a diet or specific nutrition plan? **Yes** **No**

Please check all that apply:

☐ Keep a food journal

☐ Use a food tracking app

☐ Use a FitBit or other activity tracking device

☐ Take daily vitamins

☐ Eat breakfast everyday

☐ Eat after 8pm

If yes, please describe your plan: _____

How would you rate your current nutrition? **Very healthy** **Healthy** **Somewhat Healthy** **Not Healthy**

List your 3 biggest challenges with choosing & following a nutrition plan: _____

Release of Liability

☐ I understand that the nature of certain injuries, illness or conditions may require a doctor's release form to start or continue a fitness program.

☐ The above information is true and correct to the best of my knowledge.

Participation in any exercises including Core Effects Personal Training involves the risk of injury to you, whether you or someone else causes it. Specific risks vary from one activity to another and the risk range from minor injuries to major injuries, such as catastrophic injuries including death. **In consideration of your participation in the activities offered by Core Effects, you understand and voluntarily accept this risk and agree that Core Effects and all training staff will not be liable for any injury, without limitation.** It is the responsibility of the client to seek competent medical care or other professional advice, regarding any concerns involved with the ability of a client to take part in physical activities. By signing this agreement, you acknowledge that you have read the foregoing and know the nature of the activities involved in personal training and you agree to all the terms of this agreement.

☐ I am the parent/guardian for the participating client

Client Signature _____ Date: _____