

# Client Profile Report

For More Information Please Call:

Phone: (250) 390-3160

Fax: (250) 390-3159

E-mail: [Info@core-essentials.net](mailto:Info@core-essentials.net)

**Please ensure that all questions are answered complete with phone numbers / fax numbers / medical contact information. A \$10.00 charge will be levied for incomplete forms.**

# SCREENING QUESTIONNAIRE

Please Fill Out All Information Below

<b>Name:</b>	<b>Date of Birth:</b>	<b>Age:</b>
<b>Address:</b>		
<b>City:</b>	<b>Province:</b>	
<b>Home Phone:</b>	<b>Work Phone:</b>	
<b>E-mail:</b>	<b>Employer:</b>	
<b>Occupation</b>		

Please Check The Box For the Appropriate Answer

Has your doctor ever said you have heart trouble:	Yes: <input type="checkbox"/>	No: <input type="checkbox"/>
Have you ever had angina pectoris, sharp pain, or heavy pressure in your chest as a result of exercise, walking, or other physical activity such as climbing stairs? (Note: This does not include the normal out of breath feeling that results from normal activity)	Yes: <input type="checkbox"/>	No: <input type="checkbox"/>
Do you experience any sharp pain or extreme tightness in your chest when you are hit with a cold blast of air?	Yes: <input type="checkbox"/>	No: <input type="checkbox"/>
Have you ever experienced rapid heart action or palpitations?	Yes: <input type="checkbox"/>	No: <input type="checkbox"/>
Have you ever had a real suspected heart attack, coronary occlusion, myocardial infarction, coronary insufficiency, or thrombosis?	Yes: <input type="checkbox"/>	No: <input type="checkbox"/>
Have you ever had rheumatic fever?	Yes: <input type="checkbox"/>	No: <input type="checkbox"/>
Do you have diabetes, hypertension, or high blood pressure?	Yes: <input type="checkbox"/>	No: <input type="checkbox"/>
Does anyone in your family have diabetes, hypertension, or high blood pressure?	Yes: <input type="checkbox"/>	No: <input type="checkbox"/>
Has more than one blood relative (parent, sibling, first cousin) had a heart attack or coronary artery disease before the age of 60?	Yes: <input type="checkbox"/>	No: <input type="checkbox"/>
Have you ever taken medications or been on a special diet to lower your cholesterol?	Yes: <input type="checkbox"/>	No: <input type="checkbox"/>
Have you ever taken digitalis, quinine, or any other drug for your heart?	Yes: <input type="checkbox"/>	No: <input type="checkbox"/>
Have you ever taken nitroglycerine or any other tablets for chest pain (tablets you take by placing under your tongue)	Yes: <input type="checkbox"/>	No: <input type="checkbox"/>
Are you overweight?	Yes: <input type="checkbox"/>	No: <input type="checkbox"/>
Are you under a lot of stress	Yes: <input type="checkbox"/>	No: <input type="checkbox"/>
Do you drink excessively	Yes: <input type="checkbox"/>	No: <input type="checkbox"/>
Do you smoke cigarettes?	Yes: <input type="checkbox"/>	No: <input type="checkbox"/>
Do you have a physical condition, impairment or disability, including a joint or muscle problem, that should be considered before you undertake an exercise program?	Yes: <input type="checkbox"/>	No: <input type="checkbox"/>
Are you more than 65 years old?	Yes: <input type="checkbox"/>	No: <input type="checkbox"/>
Are you more than 35 years old?	Yes: <input type="checkbox"/>	No: <input type="checkbox"/>
Do you exercise fewer than three times per week?	Yes: <input type="checkbox"/>	No: <input type="checkbox"/>

# HEALTH HISTORY QUESTIONNAIRE

Answer Each Question By Printing the Necessary Information. Information Confidential

In case of emergency, please notify:

Name:

Relationship:

City

Phone:

Wrk Phone:

## Medical Information

Please Print

All information is kept confidential

Physician:

Phone:

Are you under the care of a physician, chiropractor, or other health care professional for any reason?

Yes:

No:

Are you taking any medications?  
yes, complete the following)

(If Yes:  No:   
Type:

Dosage/Frequency: Reason for Taking:

Please list any allergies:

Has your doctor ever said your blood pressure was too high?

Yes:

No:

Has your doctor ever told you that you have a bone or joint problem that has been or could be made worse by exercise?

Yes:

No:

Are you unaccustomed to vigorous exercise?

Yes:

No:

Is there any reason not mentioned why you should not follow a regular exercise program?

Yes:

No:

Have you recently experienced any chest pain associated with either exercise or stress?

Yes:

No:

If you smoke, please answer the following questions

If you are a former smoker; date quit: \_\_\_\_\_

Cigar and/or pipe?: \_\_\_\_\_

How many cigarettes a day do you smoke?: \_\_\_\_\_

## Family and Personal Medical History

If there is family history for any condition, please check the box to the left. If you are personally experiencing any of these conditions, fill the information in on the line to the right.

- Asthma:
- Respiratory/Pulmonary Conditions:
- Diabetes: Type 1: \_\_\_\_\_ Type II: \_\_\_\_\_ How Long: \_\_\_\_\_
- Epilepsy: Petite Mal: \_\_\_\_\_ Grand Mal: \_\_\_\_\_ Other: \_\_\_\_\_
- Osteoporosis:

## Lifestyle and Dietary Factors

Please fill in the information below:

- Occupational Stress Level:  Low  Medium  High
- Energy Level  Low  Medium  High
- Caffeine Intake/Daily:  Alcohol Intake/Weekly
- Colds Per Year:  Anemia:
- Gastrointestinal Disorder:
- Hypoglycemia
- Thyroid Disorder:
- Pre/Postnatal

## Cardiovascular

Please fill in the information below:

- High Blood Pressure  Hypertension
- High Cholesterol
- Hyperlipidemia:
- Heart Disease
- Heart Attack  Stroke
- Angina  Gout

## Musculoskeletal Information

Please describe any past or current musculoskeletal conditions you have incurred such as muscle pulls, sprains, fractures, surgery, back pain or general discomfort:

- Head/Neck: \_\_\_\_\_
- Upper Back: \_\_\_\_\_
- Shoulder/Girdle \_\_\_\_\_
- Arm/Elbow: \_\_\_\_\_
- Wrist/Hand: \_\_\_\_\_
- Lower Back: \_\_\_\_\_
- Hip/Pelvis: \_\_\_\_\_
- Thigh/Knee: \_\_\_\_\_
- Arthritis: \_\_\_\_\_
- Hernia: \_\_\_\_\_
- Surgeries: \_\_\_\_\_
- Other: \_\_\_\_\_

## Nutritional Information

Are you on any specific food/diet plan at this time?

Yes:  No:

If yes, please list:

Do you experience any frequent weight fluctuations?

Have you experienced a recent weight gain or loss?

Yes:  No:

If yes, list change:

Over how long?

Other food/nutritional issues you want to include (*food allergies, mealtimes, etc.*)

## Work and Exercise Habits

Please check the box that best describes your work and exercise habits.

- Intense occupational and recreational exertion
- Moderate occupational and recreational exertion
- Sedentary occupational and intense recreational exertion
- Sedentary occupational and moderate recreational exertion
- Sedentary occupational and light recreational exertion
- Complete lack of all exertion

To what degree do you perceive your environment as stressful?

Work  Minimal  Moderate  Average  Extremely

Home  Minimal  Moderate  Average  Extremely

Do you work more than 40 hours a week?

Yes:  No:

Please make any other comments you feel are pertinent to your exercise program.

Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Signature of Parent: \_\_\_\_\_  
or Guardian (for participants under the age of majority)

Witness: \_\_\_\_\_

# MEDICAL RELEASE

## Please Complete The Following Information

It is my understanding that \_\_\_\_\_ will be participating in a fitness evaluation and exercise program. This patient is permitted to participate in the following activities:  
(Please check all that apply)

1. Comprehensive physical fitness assessment including:

- submaximal aerobic capacity test for cardiovascular endurance
- resting heart rate, resting blood pressure
- body composition analysis
- flexibility
- baseline upper and lower body strength measures
- Other: \_\_\_\_\_

2. Exercise/rehabilitation program including:

- resistance exercise program
- cardiovascular exercise program
- nutritional recommendations
- other: \_\_\_\_\_

Please check the appropriate response:

- This patient may participate with no restrictions
- This patient may participate with the following limitations:

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- This patient may not participate (if checked, the individual will not be accepted)
- Other

Diagnosis/Recommendations/Comments:

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## Signature

Physician Name (please print): \_\_\_\_\_

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Participant Name (please print): \_\_\_\_\_

Participant Signature: \_\_\_\_\_ Date: \_\_\_\_\_



# INFORMED CONSENT FORM

## Please Fill Out All Information Requested Below

I, (print name) \_\_\_\_\_, give my consent to participate in the physical fitness

### BENEFITS

Participation in a regular program of physical activity has been shown to produce positive changes in a number of organ systems. These changes include increased work capacity, improved cardiovascular efficiency, and increased muscular strength, flexibility, power and endurance.

### RISKS

I recognize that exercise carries some risk to the musculoskeletal system (sprains, strains) and the cardiorespiratory system (dizziness, discomfort in breathing, heart attack). I hereby certify that I know of no medical problem (except those noted below) that would increase my risk of illness and injury as a result of participation in a regular exercise program.

### TESTING AND EVALUATION RESULTS

I understand that I will undergo initial testing to determine my current physical fitness status. The testing will consist of completing this health inventory, a musculoskeletal assessment and body composition.

I further understand that such screening is intended to provide the Core Essentials with essential information used in the development of individual fitness programs. I understand that my individual results will be made available only to me. I also understand that the testing is not intended to replace any other medical test or the services of my physician. I will be provided a copy of all test results. I may share the results with whomever I please, including my personal physician. By signing this consent form I understand that I am personally responsible for my actions during my tenure at Core Essentials and that I waive the responsibility of this center if I should incur any injury as a result of my negligence.

Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Signature of Parent: \_\_\_\_\_

or Guardian (for participant under age of majority)

Witness: \_\_\_\_\_

**APPLICANT'S**  
SCREENING  
QUESTIONNAIRE

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Email: \_\_\_\_\_ Age: \_\_\_\_\_

Home Ph: \_\_\_\_\_ Work/Cell: \_\_\_\_\_

Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Regular exercise associated with many health benefits, yet any change of activity may increase the risk of injury. Please read each question carefully and answer every question honestly:

- YES • NO 1. Has a physician ever said you have a heart condition and you should only do physical activity recommended by a physician?
- YES • NO 2. When you do physical activity, do you feel pain in your chest?
- YES • NO 3. When you were not doing physical activity, have you had chest pain in the past month?
- YES • NO 4. Do you ever lose consciousness or do you lose your balance because of dizziness?
- YES • NO 5. Do you have a joint or bone problem that may be made worse by a change in your physical activity?
- YES • NO 6. Is a physician currently prescribing medications for your blood pressure or heart condition?
- YES • NO 7. Do you have insulin dependent diabetes?
- YES • NO 8. Have you seen a physiotherapist or chiropractor in the last 12 months?
- YES • NO 9. Do you have any history of problems with your back?
- YES • NO 10. If applicable, are you pregnant?
- YES • NO 11. Do you know of any other reason you should not exercise or increase your physical activity?

**If you answered yes to any of the above questions, you must talk with your doctor BEFORE you become more physically active.** If you honestly answered no to all questions you should increase your level of physical activity gradually. If your health changes so you then answer yes to any of the above questions, seek guidance from a physician.

**Please tell us of any other injuries old or new we should be aware of:**

APPLICANT'S SIGNATURE \_\_\_\_\_ DATE SIGNED \_\_\_\_\_

David Gilks, MES, PFT  
Unit C-2 6439 Portsmouth Road  
Nanaimo, BC V9V 1R6  
250-390-3160

DAVID GILKS

CORE ESSENTIALS INC



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**APPLICANT'S**  
PERMISSION TO RELEASE  
INFORMATION

Applicant Name: \_\_\_\_\_

Applicant D.O.B.: \_\_\_\_\_

Applicant Address: \_\_\_\_\_

\_\_\_\_\_

I Hereby Give Permission to contact the following individuals, as required,  
for the development of a Fitness and Rehabilitation Program:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

To release any pertinent information to Core Essentials Health Management Services for the purpose of fitness and rehabilitation programming. I further authorize Core Essentials Health Management Services to release information to such agencies and persons as may be required to assist in the safe development and implementation of fitness and rehabilitation programs.

If you have any questions about the collection or use of this information contact your Rehabilitation Consultant.

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**APPLICANT'S SIGNATURE** ..... **DATE SIGNED** .....

**APPLICANT'S  
AGREEMENT AND  
RELEASE OF LIABILITY**

Applicant Name: \_\_\_\_\_

Applicant Address: \_\_\_\_\_

In consideration of being allowed to participate in any way in the activities and programs of Core Essentials Inc. and use of its facilities, equipment and machinery, the undersigned acknowledges, appreciates and agrees that:

1. The risk of injury from the activities involved in this program including strength, flexibility and aerobic exercise and the use, supervised and unsupervised, of training equipment is significant, including the potential for permanent paralysis & death, and while particular rules, equipment, & personal discipline may reduce this risk, the risk of injury does exist; and,
2. I understand this program does not provide medical treatment, nor are its fitness professionals licensed medical professionals.
3. I KNOWINGLY AND FREELY ASSUME ALL SUCH RISKS, both known and unknown, EVEN ARISING FROM THE NEGLIGENCE OF THE RELEASEES or others, and assume full responsibility for my participation; and,
4. I willingly agree to comply, with the stated and customary terms and conditions for participation. If however I observe any unusual significant hazard during my presence or participation, I will remove myself from participation and bring such to the attention of the nearest representative of Core Essential Inc. immediately; and
5. I, for myself and on behalf of my heirs, assigns, personal representatives and next of kin, HEREBY RELEASE AND HOLD HARMLESS Core Essentials Inc. their officers, officials, agents and/or employees, other participants, sponsoring agencies, sponsors, advertisers, and if applicable, owners and lessors of premises used to conduct the event ("Releasees"), WITH RESPECT TO ANY AND ALL INJURY, DISABILITY, DEATH, or loss or damage to person or property, WHETHER CAUSED BY THE NEGLIGENCE OF THE RELEASEES OR OTHERWISE. I HAVE READ THIS RELEASE OF LIABILITY AND ASSUMPTION OF RISK AGREEMENT, FULLY UNDERSTAND ITS TERMS, UNDERSTAND THAT I HAVE GIVEN UP SUBSTANTIAL RIGHTS BY SIGNING IT, AND SIGN IT FREELY AND VOLUNTARILY WITHOUT ANY INDUCEMENT.

**APPLICANT'S SIGNATURE** ..... **DATE SIGNED** .....