



ASSESSING YOUR NEEDS:

All information received on this form will be treated as strictly confidential. Please fill out the forms **completely and accurately**. This information is essential to helping the Empower staff develop a wellness program that addresses your needs, goals and interests and is safe and effective.

| | | | |
|--------------------------------------|------|--|----------|
| Name: _____ | | Date of Birth <u> </u> / <u> </u> / <u> </u> Age: _____ | |
| M D Y | | | |
| Address: _____ | | _____ | |
| Street | City | State | Zip Code |
| Phone: _____ (h) _____ (o) _____ (c) | | | |
| Email address: _____ | | Occupation: _____ | |
| Emergency Contact _____ | | Relationship _____ | |
| Phone _____ | | Address _____ | |
| Current Weight _____ | | Current Height _____ | |

How did you hear about us? Please check all that apply.

| | | | | | | | |
|--|-----------------------------|--|------------------------------|--|------------------------------|--|-------------------|
| | Our Web Site | | Another Client Name _____ | | Referral Rewards Program | | Social Media |
| | City Search | | Empower on the Move Van | | Letter from Friend/Colleague | | Brochure |
| | Health Fair/Corporate Event | | Professional Partner | | Walk in / Drive by | | Direct Mail Piece |

Are you presently under the care of a medical doctor or a health practitioner? If yes, for what reasons?

Name: _____ Care Provided: _____

Name: _____ Care Provided: _____



Weight History

Current Weight (pounds) _____ Max lifetime weight (pounds) _____

Height (feet, inches) _____

Weight History

| Age | Weight | Age | Weight |
|-----|--------|-----|--------|
| 15 | _____ | 50 | _____ |
| 20 | _____ | 60 | _____ |
| 30 | _____ | 70 | _____ |
| 40 | _____ | 80 | _____ |

What are your goals with regard to your weight?

_____ Weight Loss

_____ Weight Gain

_____ Weight Maintenance

Have you ever had a resting metabolic test measurement?

_____ Yes

_____ No

Exercise Related Questions- Skip to next section if you presently are not exercising.

How often do you take part in physical exercise? _____

If your participation is lower than you would like it to be, what are the reasons? _____

How long have you been consistently physically active for?



What activities are you presently involved in? _____

Health History

Date of last medical check-up _____ Physician _____

Address _____

Phone Number _____

May we contact your physician to provide updates on your progress? ___ Yes ___ No

Current medical problems (check all that apply)

- | | | |
|-----------------------|-----------------------------------|------------------------------------|
| _____ Allergies | _____ Polycystic Ovarian Syndrome | _____ Food sensitivity/intolerance |
| _____ Anemia | _____ Gestational Diabetes | _____ Thyroid disease |
| _____ Anorexia | _____ Nausea/Vomiting | _____ Erectile dysfunction |
| _____ Bulimia | _____ Acid reflux | _____ Parkinson's disease |
| _____ Cancer | _____ HIV/AIDS | _____ Osteoporosis |
| _____ Celiac disease | _____ Chronic fatigue syndrome | _____ Rheumatoid arthritis |
| _____ Constipation | _____ Ulcerative Colitis | _____ Fibromyalgia |
| _____ Crohn's disease | _____ Irritable bowel syndrome | _____ Gout |
| _____ Diarrhea | _____ High blood pressure | _____ Lupus |
| _____ Diverticulitis | _____ High cholesterol | _____ Osteoarthritis |
| _____ Type 1 Diabetes | _____ High triglycerides | _____ Depression |
| _____ Type 2 Diabetes | _____ Heart disease | _____ Other |

Please list your past medical or relevant surgical history.



Please list your family medical history (indicate family member and condition).

Four horizontal lines for writing family medical history.

Have you ever been diagnosed with or received treatment for an eating disorder?

_____ Yes

_____ No

Are you concerned that you may have an eating disorder?

_____ Yes

_____ No

Women Only (Please check all that apply).

_____ Currently pregnant(_____ months)

_____ Breastfeeding

_____ Trying to become pregnant

_____ Menstrual irregularities

_____ Infertility

_____ Breast Cancer

_____ PMS

_____ Ovarian Cancer

_____ Menopause (age _____)

_____ Hysterectomy (age _____)

Do you take any medications, either prescription or non-prescription, on a regular basis? If so please list name and reason for taking.

Two horizontal lines for listing medications.



Do you take any supplements (include vitamins, minerals, herbs, weight loss supplements, etc.)? If so please list name and reason for taking.

Do you smoke? _____ If yes how many cigarettes per day/week? _____

Do you drink? _____ If yes how many glasses per week? _____

Dietary Intake

Do you have any known food allergies? If so, please list the food, your reaction and the diagnosis method if known.

Do you have any food intolerances (e.g. lactose intolerance, gluten intolerance, etc) If so, please list the food and your reaction.

Do you have any strong food dislikes? If so please list.

Do you have specific religious or cultural food preferences? If so please list.



On average, how many times per week do you eat food from outside your home?

_____ Breakfast _____ Lunch _____ Dinner _____ Snacks

Diet Preferences

_____ Vegan _____ No Wheat _____ No Lactose
 _____ Vegetarian _____ No Gluten _____ Other
 _____ Kosher _____ No Dairy

Are you currently following any specific diet plan? If yes, please list the name of the plan.

Stress and Chronic Pain

Below list your 3 biggest sources of stress and ways you currently cope with each stressor.

| STRESS | Coping Technique |
|--------|------------------|
| | |
| | |
| | |

Based on some of the common symptoms of stress (i.e. smoking, consuming more than one drink per day for women and more than two drinks/day for men, frequent insomnia, etc.) do you think you experience chronic stress? **YES / NO**

Do you have Chronic Pain such as Low Back Pain, Headaches, Migraines, Neck Pain, Tennis Elbow, Sinus Pressure, or Tendonitis? **YES / NO**

Research indicates that physical exercise and/or therapeutic massage are both great ways to combat stress and manage chronic pain.

Are you interested in learning how therapeutic massage can help you manage chronic pain and or stress? **YES / NO**



Are you interested in a FREE initial consultation/health assessment with one of Empower's professional personal trainers? **YES / NO**

Would you like more information on Empower Personal Training's other ancillary services? **YES / NO**

If yes please check below (mark all that apply):

Personal Training

Massage Therapy

Group Classes

Goals:

What are your goals with Nutrition Counseling?

1. _____

2. _____



Participant Release and Knowledge of Agreement:

No Guarantee

I understand that nutrition recommendations made by Empower Personal Training's Registered Dietitians are based upon the answers provided in my PAR-Q and health history forms. That nutrition and life skills can be a valuable component of the wellness program, but do not guarantee results in weight loss or specific nutrition goals. It is my responsibility to inform the Registered Dietitian of any significant changes in my health, which would impact my ability to pursue/achieve the goals outlined.

I have read and understand this term: _____ (initial)

Appointments

Individual appointments are scheduled for a specific time period. Initial nutrition consultations are scheduled for 1-1.5 hours. Follow up appointments are 30-60 minutes.

I have read and understand this term: _____ (initial)

Billing

I understand that Empower Personal Training accepts payment in full at the time of service. For clients' convenience packages of our services may be purchased on a pre-pay basis. Empower Personal Training accepts cash, checks made payable to Empower Personal Training, LLC, MasterCard or Visa. A \$25 fee will be assessed on returned checks.

I have read and understand this term: _____ (initial)

Cancellation

I understand that Empower Personal Training operates on a scheduled appointment basis and thus, requires that I provide a 24 hours notice when canceling an appointment. No charge will be levied should I cancel with MORE than 24 hours notice given. Should I cancel a session with less than 24 hours notice, I will be charged in full for that session

I have read and understand this term: _____ (initial)

Refunds

In the event a Client elects to cancel a package of his/her Nutrition Counseling Services, the client will be refunded 50% of the value for all unused sessions based on the package purchased. Clients that have not paid in full for their Nutrition



Counseling packages will be charged 50% of the value of the unused sessions at the time of cancellation.

I have read and understand this term: _____ (initial)

Insurance

Empower Personal Training does not currently accept insurance for nutrition counseling services. However we can provide you with a receipt of services rendered at the completion of your session for your records.

I have read and understand this term: _____ (initial)

MEDICAL RECORDS

If you have recent lab work such as lipids, blood glucose, vitamin/mineral levels or food sensitivity testing results, please bring a copy with you to your appointment.

CONFIDENTIALITY

All information received on this form will be treated as strictly confidential.

I have read this Release and Terms of Agreement and I understand all of its terms. I sign it voluntarily and with full knowledge of its significance.

Client Name: _____

Client Signature: _____ Date: _____