

SharpCoaching, Inc.



Welcome

Thank you for your interest in working with sharpcoaching, Inc. Your coach looks forward to helping you meet your wellness goals. The first step to getting you started is to complete a questionnaire that summarizes your goals, priorities, challenges, general information and medical history.

Confidentiality

Please note that your wellness coach treats all of your personal information, including your name, your email address, and communication with your coach, as private and confidential.

Confidentiality Policy

In order for your wellness coach to help you reach your full potential, it is very important, although not required, that you share your confidential personal information, openly and honestly, in the comprehensive questionnaire and during your coaching sessions.

Your coach will protect the privacy and confidentiality of all of your personal information, including your name and email address, and all communications with your coach. Only your coach will have access to your personal information.

You must provide permission in writing to your coach in order for your information to be shared with any person or organization including your employer, insurance company or healthcare provider.

Your wellness coach will maintain your client file for 12 months after the completion of your coaching program, and will delete your client file at any time if requested.

Signature

Date



Agreement of Release of Liability

In the process of being coached in all aspects of wellness, I do hereby waive, release, and forever discharge my wellness coach from any and all responsibility or liability for injuries or damages resulting from my participation in any activities or my use of fitness equipment or any other equipment or machinery arising out of my participation in any activities under the guidance of my wellness coach. I do also hereby release all of those mentioned and any others acting upon their behalf from any responsibility or liability for any injury or damage to myself, including those caused by the negligent act or omission of any of those mentioned or others acting on their behalf or in any activities of wellness coaching.

I understand that as a part of my wellness coaching program I may be coached to, or it may be suggested that I, participate in fitness activities, e.g. exercise, aerobic training, strength training, flexibility training, etc., that could be potentially hazardous. I also understand that such activities involve risks of injury and even death, and that I am voluntarily participating in these activities and using equipment and machinery with knowledge of the dangers involved. I hereby agree to expressly assume and accept any and all risks of injury or death.

I do hereby further acknowledge that I have either had a physical examination and have been given a physician's permission to participate or that I have decided to participate in activity or use of equipment and machinery without the approval of my physician and do hereby assume all responsibility and risks of injury or death from such participation and activities.

I accept the above agreement of release of liability.

Signature

Date

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General Information

Name: _____ Date of Birth: _____
Age: _____
Gender: _____

Address: _____

Home Phone: _____ Work Phone: _____

Email Address: _____

Occupation: _____

Relationship Status:
(Single, Married, etc.) _____

Children:
(# and ages) _____

What days and times your are most available? _____

My Goals, General Health History, Background

Describe your general health:
____ Excellent ____ Very Good ____ Good ____ Fair ____ Poor ____ Very Poor

Current Body Weight: _____ Goal Body Weight _____

Height: _____ Frame Size (Small/Med/Large) _____

Goals: Indicate in each goal area below specifically what you would like to achieve. Prioritize each goal on a scale from 1-5 (1 is the highest priority)

Weight Goals: _____ Nutrition Goals: _____
Priority: _____ Priority: _____

Fitness Goals: _____ Stress Management Goals: _____
Priority: _____ Priority: _____

Other Health Goals: _____
Priority: _____

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Circle the following goals which are priorities for you. Provide additional comments as needed.

Weight management
(Including # of pounds)

Increased energy/
productivity

Improved appearance

Look & feel healthier

Improved muscle strength/tone

Improvement of one or
more medical conditions

Reduced stress

Better sleep

Improved self esteem

Decreased depression

Decreased alcohol
Intake

Decrease tobacco use/
Quit smoking

Anything else that will help
you to reach your goals?

What would you like to work on
first?

How would you describe your ideal
personal coach?

Additional comments:

Physical Activity

Describe your current level of activity:

_____ Sedentary (no exercise)

_____ Mildly active (occasional, but not regular)

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_____ Active (moderate exercise, several times a week)
_____ Very active (vigorous exercise several times a week or moderate exercise almost every day)

Describe any fitness programs or physical activities you have engaged in during the past few years?

Current limitations on physical activity (e.g., knee injury prevents walking):

Describe type and duration of weekly recreational physical activities (i.e. walking the dog, gardening, bowling, etc.)

Physical activities enjoyed the most:

Physical activities you dislike:

Please list fitness equipment you own:

Do you currently belong to a health club or regularly participate in classes?

Nutrition

Typical weekday meals:
(include Breakfast, Lunch, Dinner & Snacks)

Typical weekend meals:
(include Breakfast, Lunch, Dinner & Snacks)

What snacks do you typically eat and at what time of day?

Daily liquid intake (no. of 8 ounce glasses typically consumed each day)
(all liquids- water, milk, soda, beer, wine, etc..)

List your favorite foods:

List the foods you dislike:

List any vitamins and supplements you are currently taking:
How often do you eat at restaurants in a typical week? What is your favorite restaurant?

List any weight-management program You have tried in the last 10 years:

Describe any food allergies:

What dietary habits would you like to change?



Energy Level and Metabolism

What foods provide you with the highest level of energy?

Time of day when energy level is the highest:

Time of day when energy level is the lowest:

Describe digestive problems, if any and Likely cause of digestive problems, if known:

Foods that make you sluggish:

Stress Management

Describe your general level of stress:

_____ Low _____ Medium _____ High

Describe the impact daily stress has on your health: _____ Low _____ Medium _____ High

Describe in detail typical daily and weekly and weekend schedules (time you wake up, work schedule, evening activities):

How do you feel when you wake up most mornings?

How do you feel when you go to sleep most nights?

Describe the activities that give you the most enjoyment, satisfaction, or sense of well-being:

Do you participate in any stress management Activities, please describe:

Medical History

Do you ever experience an irregular or racing heart rate during exercise or at rest? _____ Yes _____ No

Are you pregnant? _____ Yes _____ No

Are you over the age of 65 and not accustomed to vigorous exercise? _____ Yes _____ No

Is there a good reason not mentioned above why you

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should not follow an activity program? _____ Yes _____ No
If yes, please explain:

Do you often feel faint or have spells of severe dizziness? _____ Yes _____ No

Do you suffer any chest discomfort with exertion, and have you ever suffered chest pain with an increased activity or at rest? _____ Yes _____ No

Do you use tobacco? _____ Yes _____ No Do you have difficulty breathing? _____ Yes _____ No

Has any family member died of a heart attack before age 50? Include parents, grandparents and siblings. _____ Yes _____ No

Have you been diagnosed as having bradycardia (too low of a heart rate) or tachycardia (too fast of a heart rate) or any arrhythmia? _____ Yes _____ No

What is the date of your last Complete Physical Examination?

List surgeries that you have had, including any operations on your back, eyes, hernia, bones, heart, kidneys, neck, ears, lungs, other:

Have you had any surgeries in the past three months? If so, what type?

List current medications, if any:

Have you any limitations in your range of motion of any of your limbs, or your torso? _____ Yes _____ No

Circle any of the following conditions which exist currently or in the past?

- | | | |
|-----------------------|---------------------|---------------------------|
| Heart Attack | Stroke | Heart Surgery |
| High cholesterol | High blood pressure | Angina |
| Low HDL/LDL ratio | Atherosclerosis | Peripheral artery disease |
| Compulsive overeating | Bulimia | Anorexia |

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Acid reflux

Ulcers

Inflammatory bowel disease

Diabetes

Eye problems

Epilepsy

Rheumatoid arthritis

Osteoarthritis

Spinal cord damage

HIV

Cancer

Neck strain

Asthma

Emphysema

Kidney problems

Back pain

Other Injuries

Osteoporosis

Hypoglycemia

Anemia

Concussion

Vertebral disc problems

Thyroid problems

Other _____