CORE MUSCLE ACTIVATION
25 Lesmill Road - UNIT 10A

Core Muscle Activation Assessment Form

25 Lesmill Road, Unit 10A Toronto, ON M3B 2T3 T: (416) 915-2673

Specialist (here to see)	**Date**
Client Name	**Birthday M /D /Y** **Male ____ Female ____**
Street Address	**City/Province** **Postal Code**
Mobile Phone#: **Home Phone #:** **Work Phone#:**	**Email Address:** **Do we have your permission to send you email (circle one) Y / N**
Name of person who referred you	**Emergency Contact Number and Name**
Physician Name	**Physician Telephone Number**

Please, take some time to provide us with some more information. Please, circle where applicable.

**** Please, bring any reports/documents of imaging that you have had done in the past (ie. X-Rays MRI's, etc.), if applicable.**

Do we have permission to contact your physician regarding your treatment at Core Muscle Activation? Y /N
Does your physician know you intend on participating in treatment and/or an exercise program? Y / N

What is your current complaint/pain?_____

What movements or activities are limited? _____

What, if anything makes your condition worse? _____

What, if anything makes your condition better? _____

Have you had any of these conditions in the past? Y / N

If yes, was it resolved? Y / N %

Are you currently taking any medications or drugs? Y / N
If yes, please list them by name and/or associated purpose:

Do you have any of the following currently or have had in the past:
Any history of heart problems? Y / N
High/Low blood pressure? Y / N
Any chronic illness or conditions? Y / N

If yes to any of the above please explain.
_____

When were you diagnosed and by whom?
Date (approximate): _____ By:_____

Are you currently receiving treatment for it? Y / N
If yes, please describe.

What is your occupation?_____
What are your main occupational activities? (mark with an x)
On the phone ____ Computer work ____ Sitting ____ Walking ____
Driving a vehicle ____ Repetitive movements ____ Standing ____ Lifting/bending ____ Other ____ Describe:_____

Do you have any difficulty with activities of daily living? Y / N
If yes, please explain.

Do you have any surgery history? (dental, cosmetic included) Y / N
If yes, please list.

Are you currently pregnant (now or have been within the last 5 months)? Y / N
If you have been pregnant, how many times? _____
If you have been pregnant, how were your pregnancies?_____

Do you have any conditions relating to having been pregnant?

Do you have any of the following:
History of lung or breathing problems? Y / N
Diabetes? Y / N
Smoking habits? Y / N
Hernia or any condition that may be aggravated? Y / N
Orthopedic (bone/joint) issue? Y / N
If yes, please explain.

_____
Muscular issue? Y / N
If yes, please explain:
_____

Back disorder? Y / N
If yes, please explain:
_____

Do you do any formal exercise? (e.g., lifting weights, running, etc)
Check one: **never** ☐ **metimes** **oft**☐ ☐
If **sometimes** or **often**, what kind?

If **sometimes** or **often**, how many times per week do you exercise?

Do you do any informal exercise? (e.g., walking, chores, etc)
Check one: **never** ☐ **metimes** **oft**☐ ☐
If **sometimes** or **often**, what kind?

Have you been sedentary (inactive) for the past year or more? Y/N

Approximately how many hours do you sleep per night? _____

Do you wake up during the night?
Check one: **never** ☐ **metimes** **oft**☐ ☐
If **sometimes** or **often**, what time ? _____

Please describe your sleep (quality)_____
Do you have fatigue during the day? Y / N

How would describe the emotional climate of your home?

Scale: 1 = very bad, 10 = very good _____

Please rate the level of stress at your work or in other aspects of your life.
Scale: 1 = very bad, 10 = very good _____

Please describe the nature of your stress:_____

On a scale of 1-10 (1=very unhealthy; 10 = very healthy), rate your diet. _____

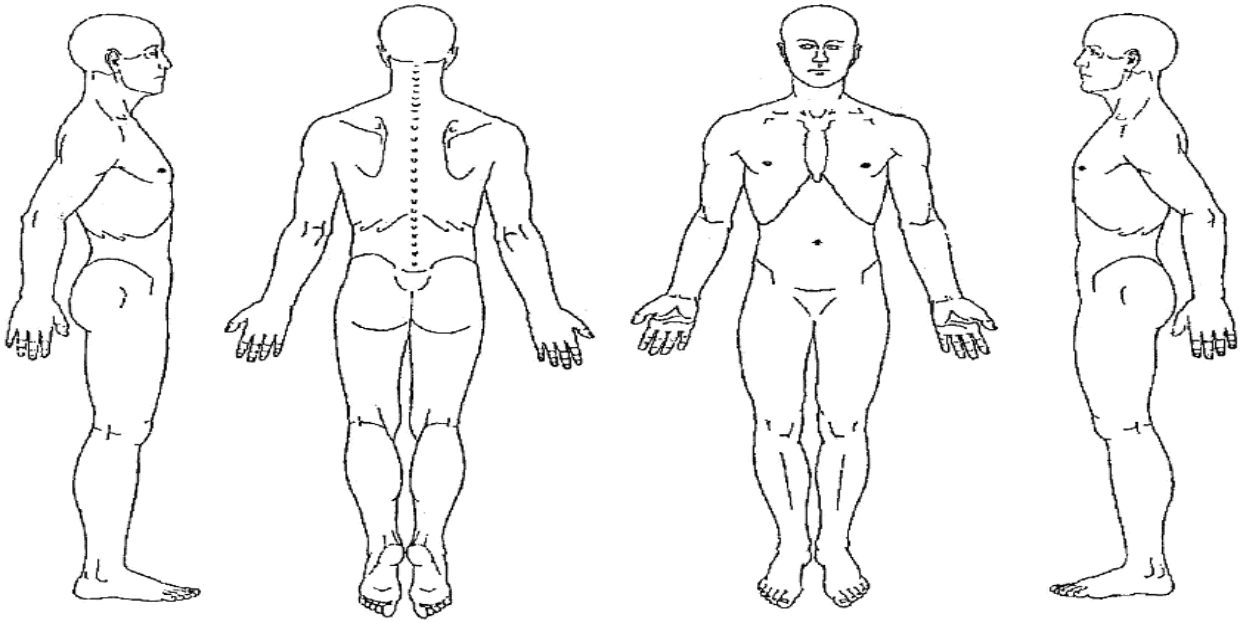
Describe what needs the most improvement in your diet. _____

Approximately how much water (in litres) do you drink per day? _____

How much time are you willing to devote to your recovery process?
Minutes per day:_____ Days per week:_____

Are you currently using other health care methods?
Physiotherapy ____ Chiropractic ____ Acupuncture ____ Reflexology ____
Osteopathy ____ Psychotherapy ____ Massage ____ Other_____

Please take some time to indicate on the figure below any areas which you are presently experiencing discomfort and/or pain



WAIVER AND RELEASE OF LIABILITY

I/We hereby understand and acknowledge that the services, training, programs and events held by Core Muscle Activation Inc. may expose me to many inherent risks, including accidents, injury, and/or illness. I/We assume all risk of injuries associated with participation including, but not limited to, falls, contact with other participants, and all other such risks being known and appreciated by me.

I/We hereby acknowledge my responsibility in communicating any physical and psychological concerns that might conflict with participation in activity. I/We acknowledge that I am physically fit and mentally capable of performing the physical activity I chose to participate in.

After having read this waiver and knowing these facts, and in consideration of acceptance of my participation and Core Muscle Activation Inc. furnishing services to me, I agree, for myself and anyone entitles to act on my behalf, to HOLD HARMLESS, WAIVE AND RELEASE Core Muscle Activation Inc., its officers, agents employees, organizers, representatives, and successors from any responsibility, liabilities, demands, or claims of any kind arising out of my participation in Core Muscle Activation Inc. services, training, programs, and/or events.

By my signature I/We indicate that I/We have read and understand this Waiver of Liability. I am aware that this is a waiver and a release of liability and I voluntarily agree to its terms.

Participants Name (Please Print): _____

Participants Signature:_____ Date:_____

_____

(Parent's signature if under 18 years of age)

I represent that I have legal capacity and authorize to act on behalf of the minor named herein.Parent/Guardian Signature:_____ Date:_____