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Coaching Agreement

This agreement is made between **Heather Clifford** ("Coach") and _____ ("Client") on this ____ day of ____, 20__. Both parties agree to the following: Coaching is a collaborative process with an ongoing relationship between the Client and Coach. The coaching experience supports the Client in establishing new behaviors. The coaching relationship is strengths-based, forward-looking, and collaborative. The coaching agenda is developed and implemented in partnership between the Client and Coach. The role of the Coach is to help the Client progress toward achieving a goal.

- The Client and Coach agree to engage fully in the coaching experience.
- The Client recognizes that coaching is not therapy, counseling, or consulting.

Confidentiality
The Coach agrees to keep all conversations and information with the Client private and confidential, as allowable by law.
No personal information will be shared with anyone without the Client's express permission. Exceptions may be made if there is an imminent threat of serious injury to oneself or someone else.

Coaching Commitment
By entering into this relationship, the Client and Coach acknowledge that the Client desires to make a behavioral change or some type of improvement in his or her life. Behavioral change often takes time to implement and sustain. The pace of change is uncertain and varies amongst individuals. As such, the Client and Coach agree to a minimum of a 3-month relationship.

Coaching Session Procedures
Coaching sessions may occur in person, by phone, through video conference, or over email, depending on the venue that works best for the Client and what coaching package is selected.

- The Coach and Client agree to adhere to established appointment times.
- The Coach and Client agree to begin and finish all appointments on time. If the Client is more than 15 minutes late to an appointment, the Coach will assume that the appointment is canceled and the Client will be responsible for the full coaching fee. If the Coach is more than 15 minutes late to an appointment, the Client may assume that the session is canceled and the Client shall not be responsible for any payment for that session.
- The Client agrees to cancel or reschedule an appointment at least 24 hours in advance, without a change fee. Any changes or cancellations within 24 hours are subject to a 50% cancellation fee.

Coaching Fees

- Specific coaching fees and packages are outlined in Schedule 1. For each of these packages, the Coach requests a 3-month commitment from the Client. If the Client desires to terminate the relationship prior to 3 months, at least 30 days advance notice is required for a full refund of remaining sessions.

Fees are payable at the first of the month, and prior to the coaching services being provided each month.
Payments may be made by cash, check, credit card, or electronic funds transfer (EFT).

Heather Clifford			
Coach	**Date**	**Client**	**Date**

Note: This document has been prepared to serve as a guide to improve understanding. Coaches should not assume that this form will provide adequate protection in the event of a lawsuit. Please see an attorney before creating, distributing, and collecting any legal documents, including contracts, informed consent forms, and waivers.

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Perceived Stress Scale

The questions in this scale ask you about your feelings and thoughts during the last month. In each case, you will be asked to indicate by circling how often you felt or thought a certain way.

Name	Date	Age	Gender

	Never	Almost Never	Sometimes	Often	Very Often
1. In the last month, how often have you been upset because of something that happened unexpectedly?	0	1	2	3	4
2. In the last month, how often have you felt that you were unable to control the important things in your life?	0	1	2	3	4
3. In the last month, how often have you felt nervous and “stressed”?	0	1	2	3	4
4. In the last month, how often have you felt confident about your ability to handle your personal problems?	0	1	2	3	4
5. In the last month, how often have you felt that things were going your way?	0	1	2	3	4
6.In the last month, how often have you found that you could not cope with all the things that you had to do?	0	1	2	3	4
7. In the last month, how often have you been able to control irritations in your life?	0	1	2	3	4
8. In the last month, how often have you felt that you were on top of things?	0	1	2	3	4
9. In the last month, how often have you been angered because of things that were outside of your control?	0	1	2	3	4
10. In the last month, how often have you felt difficulties were piling up so high that you could not overcome them?	0	1	2	3	4

The PSS Scale is reprinted with permission of the American Sociological Association, from Cohen, S., Kamarck, T., and Mermelstein, R.(1983). A global measure of perceived stress. Journal of Health and Social Behavior, 24, 386-396.
Cohen, S. and Williamson, G. Perceived Stress in a Probability Sample of the United States. Spacapan, S. and Oskamp, S. (Eds.) The Social Psychology of Health. Newbury Park, CA: Sage, 1988.

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PAR-Q+

THE PHYSICAL ACTIVITY READINESS QUESTIONNAIRE FOR EVERYONE

The health benefits of regular physical activity are clear; more people should engage in physical activity every day of the week. Participating in physical activity is very safe for MOST people. This questionnaire will tell you whether it is necessary for you to seek further advice from your doctor OR a qualifed exercise professional before becoming more physically active.

GENERAL HEALTH QUESTIONS

Please read the 7 questions below carefully and answer each one honestly: check YES or NO.	**YES**	**NO**
1) Has your doctor ever said that you have a heart condition ☐ OR high blood pressure ☐ ?	☐	☐
2) Do you feel pain in your chest at rest, during your daily activities of living, **OR** when you do physical activity?	☐	☐
3) Do you lose balance because of dizziness **OR** have you lost consciousness in the last 12 months? Please answer **NO** if your dizziness was associated with over-breathing (including during vigorous exercise).	☐	☐
4) Have you ever been diagnosed with another chronic medical condition (other than heart disease or high blood pressure)? **PLEASE LIST CONDITION(S) HERE:** _____	☐	☐
5) Are you currently taking prescribed medications for a chronic medical condition? **PLEASE LIST CONDITION(S) AND MEDICATIONS HERE:** _____	☐	☐
6) Do you currently have (or have had within the past 12 months) a bone, joint, or soft tissue (muscle, ligament, or tendon) problem that could be made worse by becoming more physically active? Please answer **NO** if you had a problem in the past, but it does not limit your current ability to be physically active. **PLEASE LIST CONDITION(S) HERE:** _____	☐	☐
7) Has your doctor ever said that you should only do medically supervised physical activity?	☐	☐

If you answered NO to all of the questions above, you are cleared for physical activity. Please sign the PARTICIPANT DECLARATION. You do not need to complete Pages 2 and 3.

- Start becoming much more physically active – start slowly and build up gradually.
- Follow International Physical Activity Guidelines for your age (www.who.int/dietphysicalactivity/en/).
- You may take part in a health and ftness appraisal.
- If you are over the age of 45 yr and NOT accustomed to regular vigorous to maximal efort exercise, consult a qualifed exercise professional before engaging in this intensity of exercise.
- If you have any further questions, contact a qualifed exercise professional.

PARTICIPANT DECLARATION If you are less than the legal age required for consent or require the assent of a care provider, your parent, guardian or care provider must also sign this form.

I, the undersigned, have read, understood to my full satisfaction and completed this questionnaire. I acknowledge that this physical activity clearance is valid for a maximum of 12 months from the date it is completed and becomes invalid if my condition changes. I also acknowledge that the community/ftness centre may retain a copy of this form for records. In these instances, it will maintain the confdentiality of the same, complying with applicable law.

Name	Date	Signature	Witness	Guardian/Care Provider Signature

If you answered YES to one or more of the questions above, COMPLETE PAGES 2 AND 3.

Delay becoming more active if:

- You have a temporary illness such as a cold or fever; it is best to wait until you feel better.
- You are pregnant - talk to your health care practitioner, your physician, a qualifed exercise professional, and/or complete the ePARmed-X+ at **www.eparmedx.com** before becoming more physically active.
- Your health changes - answer the questions on Pages 2 and 3 of this docum

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PAR-Q+

FOLLOW-UP QUESTIONS ABOUT YOUR MEDICAL CONDITION(S)

1. Do you have Arthritis, Osteoporosis, or Back Problems?
If the above condition(s) is/are present, answer questions 1a-1c — If **NO** ☐ go to question 2

1a. Do you have difficulty controlling your condition with medications or other physician-prescribed therapies?	**YES** ☐	**NO** ☐
1b. Do you have joint problems causing pain, a recent fracture or fracture caused by osteoporosis or cancer, displaced vertebra (e.g., spondylolisthesis), and/or spondylolysis/pars defect (a crack in the bony ring on the back of the spinal column)?	**YES** ☐	**NO** ☐
1c. Have you had steroid injections or taken steroid tablets regularly for more than 3 months?	**YES** ☐	**NO** ☐

2. Do you currently have Cancer of any kind?
If the above condition(s) is/are present, answer questions 2a-2b — If **NO** ☐ go to question 3

2a. Does your cancer diagnosis include any of the following types: lung/bronchogenic, multiple myeloma (cancer of plasma cells), head, and/or neck?	**YES** ☐	**NO** ☐
2b. Are you currently receiving cancer therapy (such as chemotheraphy or radiotherapy)?	**YES** ☐	**NO** ☐

3. Do you have a Heart or Cardiovascular Condition? ***This includes Coronary Artery Disease, Heart Failure, Diagnosed Abnormality of Heart Rhythm***
If the above condition(s) is/are present, answer questions 3a-3d — If **NO** ☐ go to question 4

3a. Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer **NO** if you are not currently taking medications or other treatments)	**YES** ☐	**NO** ☐
3b. Do you have an irregular heart beat that requires medical management? (e.g., atrial fibrillation, premature ventricular contraction)	**YES** ☐	**NO** ☐
3c. Do you have chronic heart failure?	**YES** ☐	**NO** ☐
3d. Do you have diagnosed coronary artery (cardiovascular) disease and have not participated in regular physical activity in the last 2 months?	**YES** ☐	**NO** ☐

4. Do you have High Blood Pressure?
If the above condition(s) is/are present, answer questions 4a-4b — If **NO** ☐ go to question 5

4a. Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer **NO** if you are not currently taking medications or other treatments)	**YES** ☐	**NO** ☐
4b. Do you have a resting blood pressure equal to or greater than 160/90 mmHg with or without medication? (Answer **YES** if you do not know your resting blood pressure)	**YES** ☐	**NO** ☐

5. Do you have any Metabolic Conditions? ***This includes Type 1 Diabetes, Type 2 Diabetes, Pre-Diabetes***
If the above condition(s) is/are present, answer questions 5a-5e — If **NO** ☐ go to question 6

5a. Do you often have difficulty controlling your blood sugar levels with foods, medications, or other physician- prescribed therapies?	**YES** ☐	**NO** ☐
5b. Do you often suffer from signs and symptoms of low blood sugar (hypoglycemia) following exercise and/or during activities of daily living? Signs of hypoglycemia may include shakiness, nervousness, unusual irritability, abnormal sweating, dizziness or light-headedness, mental confusion, difficulty speaking, weakness, or sleepiness.	**YES** ☐	**NO** ☐
5c. Do you have any signs or symptoms of diabetes complications such as heart or vascular disease and/or complications affecting your eyes, kidneys, **OR** the sensation in your toes and feet?	**YES** ☐	**NO** ☐
5d. Do you have other metabolic conditions (such as current pregnancy-related diabetes, chronic kidney disease, or liver problems)?	**YES** ☐	**NO** ☐
5e. Are you planning to engage in what for you is unusually high (or vigorous) intensity exercise in the near future?	**YES** ☐	**NO** ☐

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PAR-Q+

6. Do you have any Mental Health Problems or Learning Difficulties? ***This includes Alzheimer's, Dementia, Depression, Anxiety Disorder, Eating Disorder, Psychotic Disorder, Intellectual Disability, Down Syndrome***
If the above condition(s) is/are present, answer questions 6a-6b If **NO** ☐ go to question 7

6a. Do you have diffculty controlling your condition with medications or other physician-prescribed therapies? (Answer **NO** if you are not currently taking medications or other treatments)	**YES** ☐	**NO** ☐
6b. Do you have Down Syndrome **AND** back problems affecting nerves or muscles?	**YES** ☐	**NO** ☐

7. Do you have a Respiratory Disease? This includes ***Chronic Obstructive Pulmonary Disease, Asthma, Pulmonary High Blood Pressure***
If the above condition(s) is/are present, answer questions 7a-7b If **NO** ☐ go to question 8

7a. Do you have diffculty controlling your condition with medications or other physician-prescribed therapies? (Answer **NO** if you are not currently taking medications or other treatments)	**YES** ☐	**NO** ☐
7b. Has your doctor ever said your blood oxygen level is low at rest or during exercise and/or that you require supplemental oxygen therapy?	**YES** ☐	**NO** ☐
7c. If asthmatic, do you currently have symptoms of chest tightness, wheezing, labored breathing, consistent cough (more than 2 days/week), or have you used your rescue medication more than twice in the last week?	**YES** ☐	**NO** ☐
7d. Has your doctor ever said you have high blood pressure in the blood vessels of your lungs?	**YES** ☐	**NO** ☐

8. Do you have a Spinal Cord Injury? ***This includes Tetraplegia and Paraplegia***
If the above condition(s) is/are present, answer questions 8a-8c If **NO** ☐ go to question 9

8a. Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer **NO** if you are not currently taking medications or other treatments)	**YES** ☐	**NO** ☐
8b. Do you commonly exhibit low resting blood pressure significant enough to cause dizziness, light-headedness, and/or fainting?	**YES** ☐	**NO** ☐
8c. Has your physician indicated that you exhibit sudden bouts of high blood pressure (known as Autonomic Dysreflexia)?	**YES** ☐	**NO** ☐

9. Have you had a Stroke? ***This includes Transient Ischemic Attack (TIA) or Cerebrovascular Event***
If the above condition(s) is/are present, answer questions 9a-9c If **NO** ☐ go to question 10

9a. Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer **NO** if you are not currently taking medications or other treatments)	**YES** ☐	**NO** ☐
9b. Do you have any impairment in walking or mobility?	**YES** ☐	**NO** ☐
9c. Have you experienced a stroke or impairment in nerves or muscles in the past 6 months?	**YES** ☐	**NO** ☐

10. Do you have any other medical condition not listed above or do you have two or more medical conditions?
If the above condition(s) is/are present, answer questions 10a-10c If **NO** ☐ read the Page 4 recommendations

10a. Have you experienced a blackout, fainted, or lost consciousness as a result of a head injury within the last 12 months **OR** have you had a diagnosed concussion within the last 12 months?	**YES** ☐	**NO** ☐
10b. Do you have a medical condition that is not listed (such as epilepsy, neurological conditions, kidney problems)?	**YES** ☐	**NO** ☐
10c. Do you currently live with two or more medical conditions?	**YES** ☐	**NO** ☐

PLEASE LIST YOUR MEDICAL CONDITION(S) AND ANY RELATED MEDICATIONS HERE: _____

_____

GO to Page 4 for recommendations about your current medical condition(s) and sign the PARTICIPANT DECLARATION.

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PAR-Q+

If you answered NO to all of the FOLLOW-UP questions (pgs. 2-3) about your medical condition, you are ready to become more physically active - sign the PARTICIPANT DECLARATION below:

- It is advised that you consult a qualified exercise professional to help you develop a safe and effective physical activity plan to meet your health needs.
- You are encouraged to start slowly and build up gradually - 20 to 60 minutes of low to moderate intensity exercise, 3-5 days per week including aerobic and muscle strengthening exercises.
- As you progress, you should aim to accumulate 150 minutes or more of moderate intensity physical activity per week.
- If you are over the age of 45 yr and **NOT** accustomed to regular vigorous to maximal effort exercise, consult a qualified exercise professional before engaging in this intensity of exercise.

STOP

If you answered **YES** to **one or more of the follow-up questions** about your medical condition:

You should seek further information before becoming more physically active or engaging in a fitness appraisal. You should complete the specially designed online screening and exercise recommendations program - the **ePARmed-X+ at www.eparmedx.com** and/or visit a qualified exercise professional to work through the ePARmed-X+ and for further information.

Delay becoming more active if:

- You have a temporary illness such as a cold or fever; it is best to wait until you feel better.
- You are pregnant - talk to your health care practitioner, your physician, a qualifed exercise professional, and/or complete the ePARmed-X+ at **www.eparmedx.com** before becoming more physically active.
- Your health changes - answer the questions on Pages 2 and 3 of this docum

You are encouraged to photocopy the PAR-Q+. You must use the entire questionnaire and NO changes are permitted.

The authors, the PAR-Q+ Collaboration, partner organizations, and their agents assume no liability for persons who undertake physical activity and/or make use of the PAR-Q+ or ePARmed-X+. If in doubt after completing the questionnaire, consult your doctor prior to physical activity.

PARTICIPANT DECLARATION

- All persons who have completed the PAR-Q+ please read and sign the declaration below.
- If you are less than the legal age required for consent or require the assent of a care provider, your parent, guardian or care provider must also sign this form.

I, the undersigned, have read, understood to my full satisfaction and completed this questionnaire. I acknowledge that this physical activity clearance is valid for a maximum of 12 months from the date it is completed and becomes invalid if my condition changes. I also acknowledge that the community/fitness center may retain a copy of this form for records. In these instances, it will maintain the confidentiality of the same, complying with applicable law.

Name	Date	Signature	Witness	Guardian/Care Provider Signature

For more information, please contact

www.eparmedx.com
eparmedx@gmail.com

Citation for PAR-Q+
Warburton DER, Jamnik VK, Bredin SSD, and Gledhill N on behalf of the PAR-Q+ Collaboration. The Physical Activity Readiness Questionnaire for Everyone (PAR-Q+) and Electronic Physical Activity Readiness Medical Examination (ePARmed-X+). Health & Fitness Journal of Canada 4(2):3-23, 2011.

The PAR-Q+ was created using the evidence-based AGREE process (1) by the PAR-Q+ Collaboration chaired by Dr. Darren E. R. Warburton with Dr. Norman Gledhill, Dr. Veronica Jamnik, and Dr. Donald C. McKenzie (2). Production of this document has been made possible through fnancial contributions from the Public Health Agency of Canada and the BC Ministry of Health Services. The views expressed herein do not necessarily represent the views of the Public Health Agency of Canada or the BC Ministry of Health Services.

Key References
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2. Warburton DER, Gledhill N, Jamnik VK, Bredin SSD, McKenzie DC, Stone J, Charlesworth S, and Shephard RJ. Evidence-based risk assessment and recommendations for physical activity clearance; Consensus Document. APNM 36(S1):S266-s298, 2011.
3. Chisholm DM, Collis ML, Kulak LL, Davenport W, and Gruber N. Physical activity readiness. British Columbia Medical Journal. 1975;17:375-378.
4. Thomas S, Reading J, and Shephard RJ. Revision of the Physical Activity Readiness Questionnaire (PAR-Q). Canadian Journal of Sport Science 1992;17:4 338-345.

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Your Action Plan

Most likely you've done some coaching goal planning in the past. This time I want you to make your plan by answering the following questions thoughtfully and intentionally. Be specific. (One-liners won't do.)

Please list your motivation(s) for choosing to complete ***health coaching*** and the reasons you want to make a positive change in and for your health.

On a scale of 1 to 10 how motivated and willing are you to change?
Circle one: 1 2 3 4 5 6 7 8 9 10

What obstacles have kept you from making positive health changes in the past?

What are you willing to do in order to remove these obstacles?

List your top three physical health goals.
(Example: Reduce blood pressure so my doctor discontinues medications)

1.
2.
3.

List your top three spiritual health goals.
(Example: Grow in kindness toward myself and others)

1.
2.
3.

What are you hoping to learn from this action plan experience?

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Adverse Childhood Experience Questionnaire for Adults

Our relationships and experiences—even those in childhood—can affect our health and well-being. Difficult childhood experiences are very common. Please tell us whether you have had any of the experiences listed below, as they may be affecting your health today or may affect your health in the future. This information will help you and your provider better understand how to work together to support your health and well-being.

Instructions: Below is a list of 10 categories of Adverse Childhood Experiences (ACEs). From the list below, please place a checkmark next to each ACE category that you experienced prior to your 18th birthday. Then, please add up the number of categories of ACEs you experienced and put the total number at the bottom.

Did you feel that you didn't have enough to eat, had to wear dirty clothes, or had no one to protect or take care of you?	☐
Did you lose a parent through divorce, abandonment, death, or other reason?	☐
Did you live with anyone who was depressed, mentally ill, or attempted suicide?	☐
Did you live with anyone who had a problem with drinking or using drugs, including prescription drugs?	☐
Did your parents or adults in your home ever hit, punch, beat, or threaten to harm each other?	☐
Did you live with anyone who went to jail or prison?	☐
Did a parent or adult in your home ever swear at you, insult you, or put you down?	☐
Did a parent or adult in your home ever hit, beat, kick, or physically hurt you in any way?	☐
Did you feel that no one in your family loved you or thought you were special?	☐
Did you experience unwanted sexual contact (such as fondling or oral/anal/vaginal intercourse/penetration)?	☐

Your ACE score is the total number of checked responses: _____

Do you believe that these experiences have affected your health? ○ not much ○ some ○ a lot

Experiences in childhood are just one part of a person's life story.
There are many ways to heal throughout one's life.
Please let us know if you have questions about privacy or confidentiality.

Adopted from: California Surgeon General's Clinical Advisory Committee

REVELATION WELLNESS

LIVEWELL

Release of Liability Form

I, [Client Name], _____ hereby acknowledge that I am voluntarily participating in health coaching services provided by Heather Clifford. I understand and acknowledge that the services provided may involve physical activity, emotional challenges, and dietary recommendations and may carry some level of risk.

In consideration of being permitted to participate in these health coaching services, I agree to assume full responsibility for any risks, injuries, or damages, known or unknown, that I might incur as a result of participating in the program.

I hereby release, waive, discharge, and covenant not to sue Heather Clifford, its officers, employees, and agents from any and all liability, claims, demands, actions, and causes of action whatsoever arising out of or related to any loss, damage, or injury, including death, that may be sustained by me, or to any property belonging to me, while participating in the health coaching services provided by [Your Name/Organization].

I understand that it is my responsibility to consult with a physician prior to and regarding my participation in the health coaching services. I represent and warrant that I am physically fit and have no medical condition that would prevent my full participation in the program.

I understand that Heather Clifford is not a licensed healthcare provider and the services provided are not intended to diagnose, treat, cure, or prevent any disease. The information provided by [Your Name/Organization] is for educational and informational purposes only and should not be construed as medical advice.

I have read this liability waiver and release form, fully understand its terms, and understand that I am giving up substantial rights, including my right to sue Heather Clifford. I acknowledge that I am signing the agreement freely and voluntarily and intend by my signature to be a complete and unconditional release of all liability to the greatest extent allowed by law.

PRINT NAME: _____

EMAIL: (legible please) _____Ph: _____

SIGNATURE_____

DATE: _____

REVELATION WELLNESS

LIVEWELL

Assessment Form

PERSONAL INFORMATION

First & Last Name:

Date of Birth:

Gender:

Mobile Phone:

Email:

LIFE ASSESSMENT 1. Is anything keeping you from being the most authentic you?

2. What is holding you back?

3. What do you love and celebrate about yourself?

4. What is missing in your life?

5. Are you in a romantic relationship? If so, what is the best part about that relationship? What is the most challenging?

6. Are you fulfilled in your work?

7. How do you express yourself creatively?

8. What is the dream inside of your dying to come out? 9. Are you financially healthy or stressed? 10. What rules do you follow that you wish you could break? 11. Is there an event in your life that you wish you could forget? 12. Do you have a friend or group of friends who you feel safe to be fully known by? 13. When you think about a God who loves you, what comes up for you? 4. Is there anyone you need to forgive? 15. What do you think might lie at the root of your health challenges? 16. Have you ever been involved with witchcraft of the occult? 17. What does your body need to heal? 18. What would it take to life a life your body would love?

Questions inspired by Lissa Rankin, MD, author of Mind Over Matter and the book, Bodywise by Rachel Carlton Abrams, MD.

HEALTH ASSESSMENT

EXERCISE HABITS

1. In the past 6 months, how often have you engaged in physical activity?
   - Always - 7 days a week
   - Regularly - 3 to 4x a week
   - Semi regularly - 1-2 x a week
   - Sporadically - 1-2 x a month
2. Please explain your current exercise regime or activities performed in the past:
3. Please list any cardiovascular activities that you enjoy:
4. Please list any strength training exercises that you enjoy:
5. What are your personal barriers to exercising or sticking to a program?
6. How much time do you plan to spend on your workout program?
   - min/day
   - days/week

LIVEWELL

Assessment Form

WELLNESS GOALS

1. Why have you decided to begin or improve your exercise/ wellness program?
2. Specifically describe what you would like to accomplish in your sessions.
3. Specifically describe what you would like to accomplish through your fitness/wellness program during the next:
   - 1 Month
   - 6 Months
   - 1 Year
4. List your top 3 physical health goals?
(Example: reduce blood pressure so my doctor discontinues medications)
5. List your top 3 spiritual goals?
(Example: Grow in kindness toward myself and others)
6. What obstacles have kept you from making positive health changes in the past?
7. What are you willing to do in order to remove these obstacles?

PERSONAL HISTORY

In order to design a safe and effective coaching program, it is important that you complete the following Health History. It is crucial that you answer all the questions honestly and to the best of your ability. Please be advised that all information is kept strictly confidential.

CIRCLE THE APPROPRIATE RESPONSE. READ ALL THE QUESTIONS THOROUGHLY,

1. Has your doctor ever told you that you have heart problems? Y / N
2. Has your doctor ever told you that you have high blood pressure? Y / N
3. Have you ever had stroke or heart attack? Y / N
4. Have you ever had pain in your chest that concerned you? Y / N
5. Do you ever feel faint or have dizzy spells? Y / N
6. Have you had surgery in the last six months? Y / N

Check the appropriate condition(s) that apply to you below:

- Diabetes
- Asthma
- Heart Condition
- Epilepsy
- Pregnancy
- Arthritis
- Blood Pressure Concerns
- High Cholesterol
- Osteoporosis

Have you injured or have chronic pain in the following areas?

- Neck Elbows Wrists
- Upper Back Knees
- Lower Back
- Shoulders Hips Feet
- If yes, please explain:

LIVEWELL

Assessment Form

Please list any prescribed medications with dosages :
Please list any supplements or over the counter medications with dosages :
Please write any known reactions to exercise your medication can have on you:
Do you smoke? Y / N
Do you drink alcohol? Y / N
If so, how many drinks per week?
Are there any other reasons (health or personal) that may limit or prevent you from exercising?

READINESS TO CHANGE QUESTIONNARIE

1. Are you looking to change a specific behavior?
2.Are you willing to make this behavioral change a top priority?
3. Have you tried to change this behavior before?
4. Do you believe there are inherent risks/dangers associated with not making this behavioral change?
5. Do you have support for making this change from family, friends and loved ones?
6. Besides health reasons, do you have other reasons for wanting to change this behavior?
7. Are you prepared to be patient with yourself if you encounter obstacles, barriers, and /or setbacks?

END OF ASSESSMENT