



Core Restore
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Core Restore Training System Health History Form

PRINT CLEARLY PLEASE

Name: Phone: Cell:

Complete Address:

Email:

Sex: DOB: Age Emergency Contact #:

1. Have you ever had? (Please check the ones that apply to you)

- High blood pressure
Heart or circulation disorders
Seizures
Dizzy spells
Diabetes
Degeneration Joint Disease
Arthritis/Osteoarthritis
Scoliosis
Kyphosis
Osteoporosis
Auto Immune Deficiency Disease
Asthma
Direct Injuries/Trauma to Head/Neck
Joint swelling/stiffness
Multiple Sclerosis
Epilepsy/Seizure Disorder
Cancer/Tumors
Chronic Fatigue Syndrome
Fibromyalgia
Thyroid Condition
High Cholesterol
Recent Infections
Neuropathy Location
Smoking History
Back or Neck Problems
Car Accidents/Whiplash
Headaches
Average Hours Sleep per Night #of hours
Other

2. Please list any current medications, self prescribed medication, or dietary supplements that you are taking:

Three horizontal lines for listing medications or supplements.

3. Be very specific about your injury, surgery, and accident history. If you need to use back of form, please do so:

Three horizontal lines for describing injury, surgery, and accident history.

All clients are required to fill-out and sign a Par-Q Form prior to any exercise at Core Restore, LLC.