



# Client Profile

Today's Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Last Name \_\_\_\_\_ e-mail \_\_\_\_\_

First Name \_\_\_\_\_ Phone (most convenient) \_\_\_\_\_

Gender  Male  Female Best time to reach you: \_\_\_\_\_

Address \_\_\_\_\_ Phone (other) \_\_\_\_\_

City \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_ Referred By: \_\_\_\_\_

## Emergency Contact (Primary)

Name \_\_\_\_\_

Relationship \_\_\_\_\_

Phone (most convenient): \_\_\_\_\_

Other Phone 1: \_\_\_\_\_

Other Phone 2: \_\_\_\_\_

## Emergency Contact (Secondary)

Name \_\_\_\_\_

Relationship \_\_\_\_\_

Phone (most convenient): \_\_\_\_\_

Other Phone 1: \_\_\_\_\_

Other Phone 2: \_\_\_\_\_

## Goals

- Increase Strength
- Decrease Body Fat
- Increase Core Strength and Stability
- Increase Flexibility
- Tone all over
- Improve Cardiovascular Ability
- Maintain

## Goals

- Tone: \_\_\_\_\_
- Improve Sports Performance: \_\_\_\_\_
- Prepare for: \_\_\_\_\_
- Other: \_\_\_\_\_



# Medical History

Last Name \_\_\_\_\_ First Name \_\_\_\_\_

## Injuries

Please mark if you have injured any of these areas. Explain and date each.

<i>Joint or Bone</i>	<i>R</i>	<i>L</i>	<i>Date of Injury</i>	<i>Details</i>
Toe	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Foot	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Ankle	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Knee	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Hip	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Low Back/Spine	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Rib(s)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Upper Back/Spine	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Shoulder	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Elbow	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Wrist	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Hand	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Finger	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Neck/Spine	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Head	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Other/Misc.	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

<i>Soft Tissue</i>	<i>R</i>	<i>L</i>	<i>Date of Injury</i>	<i>Details</i>
Lower Leg	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Upper Leg	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Hip/Buttocks	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Abdominal	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Low Back	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Upper Back	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Shoulder	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Upper Arm	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Forearm	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Neck	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Other/Misc.	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

<i>Surgery</i>	<i>R</i>	<i>L</i>	<i>Date of Injury</i>	<i>Details</i>
_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____



# Medical History

Last Name \_\_\_\_\_ First Name \_\_\_\_\_

## Physician Information

Physician's Name \_\_\_\_\_ Specialist's Name (if necessary) \_\_\_\_\_  
 Office Phone \_\_\_\_\_ Specialist's Phone \_\_\_\_\_  
 Office Fax \_\_\_\_\_ Specialist's Fax: \_\_\_\_\_

## Medical Information

Medications \_\_\_\_\_

<i>Do you have:</i>	<i>No</i>	<i>Yes</i>	<i>Explain/Details</i>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Fainting	<input type="checkbox"/>	<input type="checkbox"/>	_____
Concussion	<input type="checkbox"/>	<input type="checkbox"/>	_____
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	_____
Muscle Cramps	<input type="checkbox"/>	<input type="checkbox"/>	_____
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other	<input type="checkbox"/>	<input type="checkbox"/>	_____

## Physical Readiness Questionnaire

- | <b>No</b>                | <b>Yes</b>               |   |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Has your doctor ever said that you have a heart condition AND that you should only perform physical activity recommended by a doctor? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you feel pain in your chest when you exercise?   |
| <input type="checkbox"/> | <input type="checkbox"/> | In the past month, have you experienced chest pain when NOT performing physical activity?   |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you lose your balance because of dizziness, or do you ever lose your balance?  |
| <input type="checkbox"/> | <input type="checkbox"/> | Is there any reason you should not perform physical exercise?   |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you pregnant, or have you given birth in the past 6 months?   |



# Waiver

Last Name \_\_\_\_\_ First Name \_\_\_\_\_

## Agreement and Release of Liability

1. By using the facilities, equipment and services of Fitness Therapists/Fitness Club for Women, in addition to payment of any fee or charge, I do hereby waive, release, and discharge Fitness Therapists/Fitness Club for Women and its officers, agents, employees, representatives, and all others acting on their behalf, from any and all claims or liabilities for injuries or damage to my person and/or property, including those caused by the ordinary act or omission of any of those mentioned or others acting on their behalf, arising out of, or connected with my participation in any activities, programs, or services of Fitness Therapists/Fitness Club for Women, or use of any equipment at various sites, including home, outdoor areas, provided by and/or recommended by Fitness Therapists/Fitness Club for Women. I understand that the terms of this release shall not apply to gross negligence, willful conduct, or criminal activity.

**Initials:** \_\_\_\_\_

2. I have been informed of, understand, and am aware that strength, flexibility and aerobic exercise, including the use of equipment, is potentially hazardous. I also have been informed of, understand and am aware that fitness and sports performance activities involve a risk of injury, including a remote risk of stroke, heart attack, serious disability, or death, and I am voluntarily participating in these activities, using equipment and machinery with full knowledge, understanding and appreciation of the dangers involved. I hereby agree to assume and accept any and all risks of injury and/or death. **Initials:** \_\_\_\_\_

3. I do hereby further declare myself to be physically sound and suffering from no condition, impairment, disease, infirmity, or other illness that would prevent my participation or use of equipment or machinery. I do hereby acknowledge that I have been informed of the need for a physician's approval for my participation in the exercise, activities, programs, and use of equipment. I also acknowledge that it has been recommended that I have a yearly or more frequent physical examination and consultation with my physician as to physical activity, exercise and the use of exercise equipment. I acknowledge that I have either had a physical examination and have been given my physician's permission to participate, or that I have decided to participate in the exercise activities, programs, and use of equipment without the approval of my physician and do hereby assume all responsibility for my participation in said activities, programs and use of equipment. **Initials:** \_\_\_\_\_

4. I understand that Fitness Therapists/Fitness Club for Women's provision and maintenance of an exercise program for me does not constitute an acknowledgement, representation, or indication of my physiological well-being, or a medical opinion relating there-to. **Initials:** \_\_\_\_\_

5. In the event that any provisions of this agreement should be deemed null and void, then and in that event, the remaining terms here-of shall continue to be valid and enforceable between the parties here-to. **Initials:** \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

If participant is under 18, a parent's signature is required: \_\_\_\_\_