

New Client Packet

GENERAL INFORMATION

Complete accuracy is essential for your safety!

Name _____ M F Gender _____ / _____ / _____ Date of Birth _____ Height _____ Weight _____

Street Address _____ Apt. # _____ City _____ State _____ Zip _____

Home Phone _____ Work/Cell Phone _____

Emergency Contact _____ Phone Number _____

Current Physician _____ Phone Number _____

Current Occupation _____

YES NO

Does your occupation require extended periods of sitting?

Does your occupation require extended periods of repetitive movements?

_____ Please explain

Do you often wear shoes with a heel?

Does your occupation cause you anxiety or mental stress?

Please list any recreational and sporting activities that you partake in:
(Golf, skiing, kayaking, etc...)

How many hours do you spend participating in these activities each week? _____

Please list any hobbies that you may have:
(Gardening, reading, T.V., surfing the web, etc...)

How many hours do you spend participating in these activities each week? _____

Have you ever lifted weights before?

_____ If yes, how consistently

What are your fitness related goals? _____

PHYSICAL ACTIVITY READINESS QUESTIONNAIRE (PAR-Q)

Please answer all questions accurately by checking YES or NO.

- | | YES | NO |
|--|--------------------------|--------------------------|
| 1. 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"/> |
| 2. Do you feel pain in your chest when you perform physical activity? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. In the past month have you had chest pain when you were not performing any physical activity? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you ever lose your balance because of dizziness or do you ever lose consciousness? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you have a bone or joint problem that could be made worse by a change in your physical activity? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Is your doctor currently prescribing any medication for your blood pressure or for a heart condition? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Do you know of any other reason why you should not engage in physical activity? | <input type="checkbox"/> | <input type="checkbox"/> |

If you have answered "Yes" to one or more of the above questions, consult your physician before engaging in physical activity. Tell your physician which questions you answered "Yes" to. After a medical evaluation, seek advice from your physician on what type of activity is suitable for your current condition.

PRINTED NAME

SIGNATURE

DATE

SIGNATURE OF PARENT OR GAURDIAN

DATE

CLIENT / PARTICIPANT CONSENT

Please print your name on the line provided, initial where asked, and sign with today's date at the bottom.

I _____ understand that this physical fitness program includes exercises using the cardio respiratory system (heart & Lungs) and the musculoskeletal system (muscles and bones) to improve strength, endurance, flexibility, range of joint motion, and body composition (losing fat and/or increasing weight of bone and muscle). Exercises may include aerobic (walking/ running, swimming, bicycling, or other such activities), calisthenics, stretching, and resistance training (weight lifting using weights, machines, tubing, and other tools offering resistance).

I understand that some physical tests, measurements, and assessments will be administered to determine my physical fitness levels including cardio respiratory (aerobic); musculoskeletal strength, flexibility, and joint range of motion and flexibility.

I understand that the physical fitness program, workouts, exercises, tests, measurements, and assessments previously mentioned may result in serious injury or death and I undertake them accepting full responsibility. I also understand that Joseph Bruner assumes no responsibility for any illness, accident or injury I may incur from the use of the programs, services or facilities provided.

I understand that any information given to me during this program regarding nutrition, food intake, and supplementation are general guidelines and practices. This information is not given to me as a prescribed diet or nutrition plan and will not substitute seeking further assistance and planning from a registered dietitian or nutritionist. I accept full responsibility for my intake of food, supplements, or any other substances while on this program. I agree to tell my fitness professional of any and all substance abuse, legal or otherwise, and realize that any contracts I have agreed upon may be terminated because of my illegal abuse of substances or illegal activities while in this program.

I understand that in addition to the gym facilities this program may be held outdoors or in a home that does not include access to emergency medical treatment. I accept full responsibility for this fact and understand that I will be monitored by a fitness professional trained in CPR.

I have fully read and understand the foregoing information. Any and all questions occurring to me have been answered to my satisfaction. I understand that I am free to withdraw from this program without any prejudice at any time. I am free to decline answering questions or specifics during interviews or while filling out questionnaires. I am also free to withdraw from any tests and procedures at any time. I understand that any information I have given or have been attained from testing, assessing, and measuring is confidential and will not be released to any one other than my physician or others involved in my care or exercise prescription without my permission. However, I do agree that information from these tests, measurements, assessments, and programs not identifiable to me can be used for research purposes.

Client/Participant Signature _____

DATE ____/____/____

HEALTH HISTORY

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Have you experienced:	Yes	No	Please Explain
Hospitalization?	<input type="checkbox"/>	<input type="checkbox"/>	_____
A heart attack or heart trouble?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chest pain or angina pectoris?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Coronary bypass or angioplasty?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Abnormal or positive stress test?	<input type="checkbox"/>	<input type="checkbox"/>	_____
A heart murmur noted by a physician to be significant or suggestive of a heart abnormality?	<input type="checkbox"/>	<input type="checkbox"/>	_____
High blood pressure above 145/95	<input type="checkbox"/>	<input type="checkbox"/>	_____
Impaired Circulation?	<input type="checkbox"/>	<input type="checkbox"/>	_____
A stroke?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Convulsions or loss of consciousness?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes Mellitus?	<input type="checkbox"/>	<input type="checkbox"/>	_____
High blood cholesterol?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Musculoskeletal limitations of movement?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Difficulty breathing?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis or rheumatism?	<input type="checkbox"/>	<input type="checkbox"/>	_____
An ankle injury or problems?	<input type="checkbox"/>	<input type="checkbox"/>	_____
A knee injury or problems?	<input type="checkbox"/>	<input type="checkbox"/>	_____
A hip or pelvis injury or problems?	<input type="checkbox"/>	<input type="checkbox"/>	_____
A back or spinal injury or problems?	<input type="checkbox"/>	<input type="checkbox"/>	_____
A herniated or ruptured spinal disc?	<input type="checkbox"/>	<input type="checkbox"/>	_____
A shoulder injury or problems?	<input type="checkbox"/>	<input type="checkbox"/>	_____
An elbow or wrist injury or problems?	<input type="checkbox"/>	<input type="checkbox"/>	_____
A surgery?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Increased anxiety or stress?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Depression?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Are you pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you ever used or smoked tobacco?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Are you taking any medications?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Is there any thing else we should know?	<input type="checkbox"/>	<input type="checkbox"/>	_____

I certify, to the best of my knowledge, that the above information is accurate and complete. I also understand that Joseph Bruner assumes no responsibility for any illness, accident or injury I may incur from the use of the programs, services or facilities provided. All individuals are strongly encouraged to consult with a physician before entering a non-medically supervised exercise program.

signature of client / parent or guardian

_____/_____/_____
date

signature of personal trainer

_____/_____/_____
date

Appointment Policies

Please initial each blank space:

_____ **Cancellations:** All clients are required to notify their trainer 24 hours in advance of a cancellation or reschedule. I understand this and will be charged the full session price if I fail to comply with the 24 hour policy.

_____ **No Shows:** I understand that should I miss a scheduled appointment I will be charged the full session price.

_____ **Tardiness:** I understand that should I arrive to an appointment late I will be charged for a full session. I also understand that if I am more than 15 minutes late the session will be treated as a No Show.

I understand the Appointment Policies and agree to comply with them completely. I understand that that these are simple courtesies and sign of my own free will.

Client/Guardian Signature

Date