



INTAKE FORM

Personal Information

First Name: _____ Last Name: _____
Gender: M F Height: _____ Weight: _____ DOB: ___/___/___
Address: _____
City: _____ State: _____ Zip: _____ - _____
Email: _____
Home Phone: (____) _____ Work Phone: (____) _____ Cell: _____
Occupation: _____ I was referred by: _____

Emergency Contact Information

Emergency Contact Phone #: (____) _____ Name: _____
Address: _____
City: _____ State: _____ Zip: _____ - _____
Relationship: _____

Physician Contact Information

Medical Clearance: Y N Date Obtained: ___/___/___
Name: _____ Phone: (____) _____ Fax: (____) _____
Address: _____
City: _____ State: _____ Zip: _____ - _____

Client History

How many days per week are you currently doing aerobic exercise? _____
Have you ever participated in any type of resistance training program? Y / N
Have you ever worked with a fitness professional or personal trainer? Y / N
How many days per week does exercise fit into your lifestyle? _____
Notes / comments:



Name: _____

Date: _____

Gender: () Female () Male If you are female are you currently pregnant? Yes () No ()
Age: _____

1) Do you or have you had any of the following?

() Low Back Pain () Joint- tender or muscular pain() Any other conditions aggravated by exercise () Any medical conditions an M.D. has ever recommended activity restrictions
Please explain: _____

2) Do you now have or have you had any of the following:

Pacemaker	No	Yes	Kidney problems	No	Yes
Headaches	No	Yes	Sensitive to Heat	No	Yes
Nervous Disorders	No	Yes	Hernia	No	Yes
Seizures	No	Yes	Diabetes	No	Yes
Balance Problems	No	Yes	Vision Problems	No	Yes
Hearing Problems	No	Yes	High Cholesterol	No	Yes
High Blood Pressure	No	Yes	Lung Diseases	No	Yes

Answer the following questions with a YES or NO answer:

YES

NO

- | | | |
|---|-------|-------|
| 1) Has your doctor ever said that you have a heart condition and that you should only do physical activity recommended by a doctor? | _____ | _____ |
| 2) Do you feel pain in your chest when you do physical activity? | _____ | _____ |
| 3) In the past month, have you had chest pain when you were not doing physical activity? | _____ | _____ |
| 4) Do you lose your balance because of dizziness or do you ever lose consciousness? | _____ | _____ |
| 5) Do you have a bone or joint problem that could be made worse by a change in your physical activity? | _____ | _____ |
| 6) Is your doctor currently prescribing drugs (for example, water pills) for your blood pressure or heart condition? | _____ | _____ |
| 7) Do you know of any reason why you should not do physical activity? | _____ | _____ |

Fill in the blanks:

Do you smoke? How many Cigarettes (per day): _____

Family History of heart attack prior to age 55: _____

Medications currently taking: _____



CLIENT AGREEMENT

PLEASE READ THE FOLLOWING CAREFULLY. You are held responsible for each item you initial. If you have any questions, please ask and we'll be happy to clarify.

- ❖ I agree to call at least **24 hours** in advance to change or cancel my appointments. I understand if I do not call and cancel in the amount of time I will be charged for a session.

_____ Initials

- ❖ **No refunds will be given.** All sessions must be completed within a six month period from purchase date. Thereafter, all remaining sessions are forfeited.

_____ Initials



Personal Training/Client Agreement

I, _____, desire to engage voluntarily in an exercise program in order to improve my physical fitness. I understand that the activities are designed to place a gradually increasing workload on the cardio respiratory and skeletal/muscle system and thereby attempt to improve their function. The reaction of the cardio respiratory and skeletal/muscle cannot be predicted with complete accuracy. These changes might include abnormalities of blood pressure and heart rate.

I understand that the purpose of the exercise program is to develop and maintain cardio respiratory fitness, body composition, flexibility, muscular strength, and endurance. A specific exercise program will be given based on needs, interests, and doctor recommendation. The rate of progression is regulated by participation and effort to the exercise program.

I understand that I am responsible for monitoring my own condition throughout the exercise program and should and unusual symptoms occur, i.e., nausea, high blood pressure, dizziness, respiratory complications, or abnormal fatigue, etc., I will cease participation and inform my instructor of my symptoms.

I also affirm that my questions regarding the exercise program have been answered to my satisfaction.

I have consulted my physician beginning this exercise program and have his/her approval. If, in the event a medical clearance must be obtained prior to my participation in the exercise program of the fitness assessment, I hereby grant *Addie's Studio One on One, Inc.* authorization to contact my physician and obtain written permission prior to commencement of any exercise program. I certify that I am in good health and if that condition changes, I will notify my personal trainer.

I completely understand that there are certain inherent risks while participating in exercise regimes or attending exercise classes in health and fitness facility. Such activity may include strenuous activity. I knowingly and voluntarily waive any cause of action whatsoever which may arise from any injury incurred as a result of such activity.

I hereby release *Addie's Studio One on One, Inc.*, its employees, management, officers, directors, and agents from any and all damages, claims, and demands resulting from injuries and/or causes of action arising from my use of the premises and/or equipment of *Addie's Studio One on One, Inc.* 4440 Ingraham Street, San Diego, California 92109. This release also includes any off sight training activities I choose to participate in under the direction of the trainers of *Addie's Studio One on One, Inc.*

I have fully read, understand and agree to the foregoing:

Client: _____

Signature

Date: _____

Print Name

Trainer: _____

Signature

Date: _____

Print Name