

FITNESS PROFILE HEALTH HISTORY

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email: _____

Sex: M or F Age: _____ Date of Birth: _____

Height: _____ Weight: _____

Physician's Name: _____ Phone #: _____

Date of Last Physical Exam: _____

IN CASE OF EMERGENCY CONTACT:

Name: _____ Phone #: _____

This form is not a substitute for a thorough physical examination, assessment and diagnosis by your physician. It is designed to identify clients for whom physical activity might be inappropriate at this time. Pulse Fitness Professionals, LLC strongly recommends that each member undergo a medical examination before beginning any exercise program.

The following questions are not for diagnostic or treatment purposes:

Do you currently exercise? Yes No

Have you exercised in the past? Yes No

If you currently exercise, please list your workout routines: _____

PLEASE CHECK ALL THAT APPLY

HAVE YOU EVER BEEN DIAGNOSED WITH, OR SUFFERED FROM THE FOLLOWING:

- | | |
|---|--|
| <input type="checkbox"/> Heart Attack/Heart Disease | <input type="checkbox"/> Diabetes Mellitus |
| <input type="checkbox"/> Coronary Bypass | <input type="checkbox"/> Chest Pain/Discomfort |
| <input type="checkbox"/> Embolism | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Aneurysm | <input type="checkbox"/> Back Pain |

If you checked any of the above conditions, you **MUST** have medical clearance prior to exercising and orientation.

PLEASE CHECK ALL THAT APPLY TO YOU:

GENERAL HISTORY

- Are you a male over 45 or female over 55?
- Do you currently have any illnesses or disorders? **Please specify:** _____
- Have you had major surgery or been hospitalized within the past year?
- Are you currently pregnant?

Do you have a history of the following conditions:

- Angina
- Asthma
- Bronchitis
- Cancer (specify: _____)
- Coronary heart disease, heart attack, coronary artery surgery
- Diabetes
- High Blood Pressure
- Kidney Disorder
- Liver Disease
- Stroke

CARDIOVASCULAR HISTORY

Has your doctor said you have any type of heart trouble/disease? Please explain: _____

Have you ever been diagnosed or do you have any of the following:

- Chest pain
- Faint or have dizzy spells
- History of High Blood Pressure
- History of High Cholesterol, have you ever had your cholesterol measured? _____
- Family history of heart disease, please explain: _____
- Currently smoke

MUSCULOSKELETAL HISTORY

Have you ever had any of the following?

- Arthritis
- Bone Fractures
- Chronic joint problems
- Any other past injuries to any body parts, please explain: _____
- Have you ever been through Physical Therapy, please explain: _____

OTHER MEDICAL HISTORY

Is there any other medical condition not mentioned that may limit you in physical activity: _____

Are you currently taking any medications? If yes, please explain: _____

I understand the nature of the Health History Questionnaire and I am aware that any strenuous physical activity involves risk. Accordingly, I release, discharge, absolve, and hold harmless Pulse Fitness Professionals, LLC and Fitness Instructors or student employees, and all associated from any and all liability arising out of any accident, injury, or loss sustained by me as a result of activities. I declare, to the best of my knowledge, that all my answers are true, correct, and complete.

Signature _____

Date _____

If client is a minor (under the age of 18):

Parent/Guardian Signature _____

Date _____

Many health benefits are associated with regular exercise, and the completion of PAR-Q is a sensible first step to take if you are planning to increase the amount of physical activity in your life.

For most people physical activity should not pose any problem or hazard. PAR-Q has been designed to identify the small number of adults for whom physical activity might be inappropriate or those who should have medical advice concerning the type of activity most suitable for them.

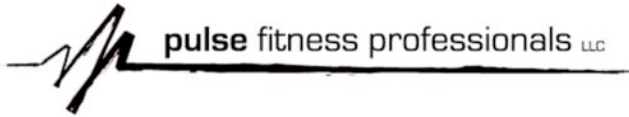
Common sense is your best guide in answering these few questions. Please read them carefully and check YES or NO opposite the question if it applies to you.

YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	1. Has your doctor ever said you have a heart condition <u>and</u> that you should only do physical activity recommend by a doctor?
<input type="checkbox"/>	<input type="checkbox"/>	2. Do you feel pain in your chest when you do physical activity?
<input type="checkbox"/>	<input type="checkbox"/>	3. In the past month, have you had chest pain when you were not doing physical activity?
<input type="checkbox"/>	<input type="checkbox"/>	4. Do you lose 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 activity?
<input type="checkbox"/>	<input type="checkbox"/>	6. Is your doctor currently prescribing drugs (for example, water pills) for your blood pressure or heart condition?
<input type="checkbox"/>	<input type="checkbox"/>	7. Do you know of <u>any other reason</u> why you should not do physical activity?

If you answered **NO** honestly to all PAR-Q questions, you can be reasonably sure that you can safely increase your level of physical activity gradually.

If you answered **YES** to one or more PAR-Q questions, you should consult your physician if you have not done so recently before starting an exercise program.

Participant Signature: _____	Date: _____
Parent/Guadian Signature: _____	Date: _____



WAVIER INFORMED CONSENT CANCELLATION POLICY

Informed Consent

By signing this document, I acknowledge that I have voluntarily chosen to participate in a program of progressive physical exercise, which can enhance the musculoskeletal and cardiorespiratory systems. In signing this document, I acknowledge being informed of the possible strenuous nature of the program and the potential for unusual, but possible, physiological results including, but not limited to, abnormal blood pressure, fainting, heart attack or death. By signing this document, I assume all risk for my health and well being and hold harmless of any responsibility, the instructor, facility or any persons involved with this program and testing procedures. I understand that questions about exercise procedures and recommendations are encouraged and welcomed.

Participant Signature: _____	Date: _____
Parent/Guadian Signature: _____	Date: _____

Wavier

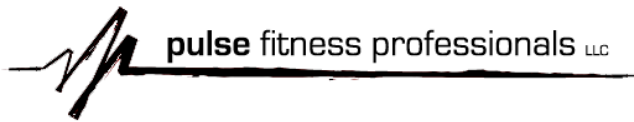
By signing this document, I acknowledge that I have been informed of the need to obtain a physician's examination and approval prior to beginning this exercise program. I fully understand that the program may be strenuous and choose to participate completely voluntarily. I accept all responsibility for my health and any resultant injury or mishap that may affect my wellbeing, or health in any way. I hold harmless of any responsibility, the instructor, facility or any persons involved with this program or testing procedures.

Participant Signature: _____	Date: _____
Parent/Guadian Signature: _____	Date: _____

24 Hour Cancellation Policy

You, as the client, have the ability to cancel at any time. As a professional courtesy, you need to provide 24 hours notice when canceling an appointment. If you do not provide 24 hours notice, you will be charged for that session. In an extreme circumstance, the situation will be reviewed. Extreme circumstances include, but are not limited to, car trouble, illness, or death. The assigned Personal Trainer does have the right to ask for proof of any such incident. If there should be a discrepancy, the ultimate decision will be left to management.

Participant Signature: _____	Date: _____
Parent/Guadian Signature: _____	Date: _____



PAYMENT POLICIES

PAYMENT POLICY

You must always pay for your session in advance. Services are invoiced on the 15th of each month for next month's services. All invoices are to be paid in full by the 1st of each month to reserve a scheduled time. All invoices will be sent through e-mail unless otherwise requested. Cash, check, or credit card payments are accepted. Checks are to be made out to 'Pulse Fitness Professionals'.

ELECTRONIC FUNDS TRANSFER

EFT is available upon request. A valid credit card or debit card of choice must be supplied in the box labeled EFT below. Services purchased through EFT will automatically be charged on the 1st of each month for that month's service. You may only stop EFT billing by cancelling in writing. All written EFT cancellation requests must be mailed to 428 N. Broadway Pitman, NJ 08071.

REFUNDS

No refunds will be given once a program is started. If a client is unable to complete the training due to an injury that occurred outside the Pulse Fitness Professionals LLC Program or other relevant circumstances that will not permit the client to finish, the remaining credit will be kept on the account. The remaining credit is transferable but non-refundable. The client may transfer any remaining credit to any other individual they shall choose. If the client chooses not to use or transfer his/her remaining credit, it will then be forfeited.

Cash refunds will not be given. Individuals granted refunds will receive a credit for the amount paid, which may be used towards the purchase of other Pulse Fitness Professionals LLC services.

SCHEDULED APPOINTMENTS

To get the most out of our efforts, please be ready to exercise at the appointment time. Keep in mind that when you are late to a session, it will end at the scheduled time. If you are more than 30 minutes late, it will be considered a no-show and you will be charged.

EFT BILLING:

Name on card: _____

Billing Address: _____

Card Number: _____ Card Type: _____

Exp Month/Exp Year: _____ CVV2: _____

Email Address for e-invoices _____

I understand this Policy Form and its conditions.

Signature _____

Date _____

If client is a minor (under the age of 18):

Parent/Guardian Signature _____

Date _____

ACTIVITY

Please indicate the reasons why you want to join an exercise program.

- Weight reduction
- Doctor's recommendation, **please specify:** _____
- Wellness
- Improve physical appearance, **please explain:** _____
- Other, **please specify:** _____

Do you engage in any recreational or leisure-time physical activities on a regular basis? Yes No

If yes, what activities? _____

Have you ever participated in a formal exercise routine? Yes No

If yes, what were your favorite exercises? **Please specify:** _____

Which type of exercise would you most prefer?

- Resistance Training
- Walking/Jogging/Running
- Fitness Classes
- Boxing/Kickboxing
- Other, **please specify:** _____

Which type of exercise do you least prefer?

- Resistance Training
- Walking/Jogging/Running
- Fitness Classes
- Boxing/Kickboxing
- Other, **please specify:** _____

Do you participate in any stretching activities? **Please explain:** _____

NUTRITION

Do you have any food allergies? Yes No

If yes, what type? **Please specify:** _____

Do you drink alcoholic beverages? Yes No

If yes, how often per week? **Please specify:** _____

Are you currently or have you ever followed a weight reduction diet plan? Yes No

If yes, how long and what type? **Please specify:** _____

Did your physician recommend the plan? Yes No

OTHER

Favorite genre of music: _____

Favorite musician/song to workout to: _____

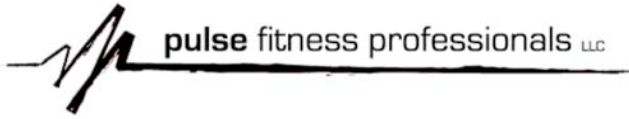
GOALS

Do you have any goals that you would like to achieve? Yes No

Please specify: _____

What are some goals you would like to accomplish? **Please explain:**

- 6 weeks, _____
- 3 months, _____
- 6 months, _____
- 1 year, _____
- Specific goal, _____
- Other, **please specify:** _____



PHYSICIAN'S APPROVAL

Certified Personal Trainer _____

_____ has been examined by me and has my

Participant's Name

approval to participate in a progressive exercise program. I understand the physical and physiological stressors of the program and see no reason why the above named person should not participate.

Physician's Signature

Date

Type of Activity:

Intensity:

Cardiovascular

Resistance Training

Flexibility

Other

Physician's Recommendations / Contraindications:

