**Please answer questions as accurately as possible. Your responses will be treated in a confidential manner.**

# A) Client Demographics

Name: 

Address:  ZIP: 

Home Phone: Mobile Phone: 

Fax #:  E-mail: 

D.O.B.  Referred by:

What is your height?  What is your current weight? 

At what body weight did you, or would you, feel best at? 

How would you characterize your current lifestyle?

Highly Stressful  Moderately Stressful  Low in Stress 

**Contacts:**

Doctor:  Phone: 

Hospital: Fax #: 

**Contact In Case of an Emergency:**

Name:  Phone: 

# B) Coronary Artery Disease (CAD) Risk Factors

1. Are you a male older than 45 years?  Yes  No, or a female older than 55 years?  Yes  No
2. Do you have a father or brother who had a heart attack or sudden death before the age of 55?  Yes  No

A mother or sister who has had a heart attack or sudden death before 65?  Yes  No

1. Do you smoke?  Yes  No If yes, how many cigarettes per day? 
2. Do you have diabetes (or currently medicated for high blood glucose)?  Yes  No

Do you have Prediabetes (or currently medicated for high blood glucose)?  Yes  No

1. Do you have high blood pressure (or currently medicated for high blood pressure)?  Yes  No
2. Do you have high cholesterol (or currently medicated for high cholesterol)?  Yes  No
3. Do you lead a sedentary lifestyle?  Yes  No

##### C) Known Diseases and Symptoms

###### Known Diseases

Do you have any personal history of coronary or atherosclerotic disease (stents, bypass, etc.)?  Yes  No

Do you have any personal history of metabolic disease (thyroid, renal (kidney), liver?  Yes  No

Suggestive Symptoms:

Have you been diagnosed with or exhibited symptoms of any of the following conditions:

 Angina  Shortness of Breath  Asthma

 Rapid Heart Rate  Ankle Edema  Dizziness of Fainting

 Breathing Problems at Night  Known Heart Murmur  Claudication

 Cardiac Surgery  Vascular Disease  Respiratory Infections

 Abnormal EKG  Thrombophlebitis  Epilepsy

 Embolism  Fixed Rate Pacemaker  Internal Defibrillator

 Aneurysm  Valve Disease  Emphysema

 Stroke  Anemia

If you checked off any of the above conditions, please explain:





Please list any prescription medications that you are taking: 





Please list any non-prescription medications that you are taking: 

Do you have any other non-cardiac related conditions or diseases?  Yes  No

If yes, please explain: 

List the date of your last physical examination: 

Would you be willing to provide us with a copy of the blood chemistry panel?  Yes  No

##### D) Injuries or Other Orthopedic Limitations

Check the areas that have been injured both recently and in the past.

 Neck  Shoulder  Hip  Arthritis

 Spine  Elbow  Knee  Bursitis

 Lower Back  Wrist  Ankle  Osteoporosis

 Spinal Stenosis  Degenerative Disc Disease  Nerve Damage  Other

If you DO check, please specify “right or left” if appropriate, and explain: 

Are you presently receiving physical therapy, chiropractic, or any other form of rehabilitative therapy?  Yes  No

May we contact your therapist?  Yes  No

Therapist Name:  Phone Number: 

Are you aware of any medical or other personal limitations not covered by this questionnaire, which would restrict your participation in a program of physical activity?  Yes  No

If yes, please specify 

## E) Your Health and Exercise Interests

 Weight Training  Massage Therapy  Nutritional Counseling

 Running  Walking  Yoga/Tai Chi/Meditation

 Pilates  Cycling  Swimming

 Golf  Tennis  Stretching

 Competitive Sports  Rehabilitative Exercise Therapy  Aquatic physical therapy

## F) Health and Fitness Objectives

Please list your goals for this program

1: 

Mobile Health and Fitness has requested the above information for informational purposes only. We do not purport to render medical advice to client. If you have questions about the appropriateness of any activity or program, in light of your medical history, please contact your physician.

Release of Liability Waiver

Because physical exercise can be strenuous and subject to risk of serious injury, we urge you to obtain a physical examination from a doctor before using any exercise equipment or participating in any exercise activity. You agree that by participating in physical exercise, physical therapy or massage therapy activities, you do so entirely at your own risk. Additional recommendations for food supplements, or weight reduction products, are entirely your responsibility and you should consult a physician prior to undergoing any dietary or food supplement changes. You agree that you are voluntarily participating in these activities and assume all risks of injury, illness, or death.

You acknowledge that you have carefully read this “waiver and release” and fully understand that it is a release of liability. You expressly agree to release and discharge the trainer or therapist from any and all claims or causes of action and you agree to voluntarily give up or waive any right that you may otherwise have to bring a legal action against the trainer or therapist for personal injury or property damage.

If any portion of this release from liability shall be deemed by a Court of competent jurisdiction to be invalid, then the remainder of this release from liability shall remain in full force and effect and the offending provision or provisions severed here from.

By signing this release, I acknowledge that I understand its content and that this release cannot be modified orally.

**Printed Name:** 
 **Dated:** 

Personal Trainer Waiver Form-1/2001 (Form #5A)

Contract and Cancellation Notice Agreement

I retain Mobile Health & Fitness to render Personal Training, Physical Therapy, and/or Massage Therapy services.

I understand that I may cancel any appointment with my therapist by giving 24 hours’ notice. I also understand that if I fail to provide the aforementioned cancellation notice, as indicated, I will be charged for the full session fee.

**Printed Name:**  **Date** 

**Therapist/Trainer:**  **Date** 

### Thank you for taking the time to complete this questionnaire