

Fitness Center Informed Consent Form

I, (print name), _____ give my consent to participate in the physical fitness evaluation program conducted by Missy's Enterprises, LLC.

Benefits

Participation in a regular program of physical activity has been shown to produce positive changes in a number of organ systems. These changes include increased work capacity, improved cardiovascular efficiency, and increased muscular strength, flexibility, power and endurance.

Risks

I recognize that exercise carries some risk to the musculoskeletal system (sprains, strains) and the cardio respiratory system (dizziness, discomfort in breathing, heart attack). I hereby certify that I know of no medical problem (except those noted below) that would increase my risk of illness and injury as a result of participation in a regular exercise program.

Testing and Evaluation Results

I understand that I will undergo initial testing to determine my current physical fitness status. The testing will consist of completing this health inventory, taking a step test or bicycle ergo meter test for cardiovascular fitness, and being tested for muscular fitness and body composition.

I further understand that such screening is intended to provide the Fitness Center with essential information used in the development of individual fitness programs. I understand that my individual results will be made available only to me. I also understand that the testing is not intended to replace any other medical test or the services of my physician. I will be provided a copy of all test results. I may share the results with whomever I please, including my personal physician. By signing this consent form I understand that I am personally responsible for my actions during my tenure at Generic Fitness, and that I waive the responsibility of this center if I should incur any injury as a result of my negligence.

Signed: _____ Date: ___/___/___

Witness: _____ Date: ___/___/___

HEALTH HISTORY QUESTIONNAIRE

Answer each question by printing the necessary information. Your answers will be kept confidential.

Name: _____

Date of Birth: _____

Address: _____

City: _____

State: _____ Zip: _____

Home Phone: _____

Work Phone: _____

Employer: _____

Occupation: _____

Physician: _____

Phone: _____

Address: _____

City: _____

State: _____ Zip: _____

In case of emergency, please notify

Name: _____

Relationship: _____

City: _____

State: _____ Zip: _____

Phone: _____

1. Are you under the care of a physician, chiropractor, or other health care professional for any reason? Yes ___ No ___

If yes, list reason:

2. Are you taking any medication? Yes ___ (if yes, complete the following) No ___

Type	Dosage/Frequency	Reason for taking
------	------------------	-------------------

3. Please list any allergies:

I am not aware of any disease or disorder that would complicate my participation in a testing or exercise programs, other than the medical conditions I have checked below.

Age: _____ Gender: Male ___ Female ___

Note: In order to assist you in the development of a rewarding physical fitness program, we need to have your honest and accurate responses.

1. Has your doctor ever said your blood pressure was too high? Yes ___ No ___
2. Has your doctor ever told you that you have a bone or joint problem that has been or could be made worse by exercise? Yes ___ No ___
3. Are you over the age 65? Yes ___ No ___
4. Are you unaccustomed to vigorous exercise? Yes ___ No ___
5. Is there any reason not mentioned here why you should not follow a regular exercise program? Yes ___ No ___

If so, please explain.

6. Have you recently experienced any chest pain associated with either exercise or stress?

Yes ___ No ___

If so, please explain.

7. Do you have a family history of any of the following conditions?

- | | |
|--|--|
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Heart Attack |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Angina |
| <input type="checkbox"/> Abnormal EKG | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Other heart condition |

SMOKING

Please check the answer that best describes your habits:

Non-user or former user. Date quit ___/___/_____

- Cigar and/or pipe
- 15 or less cigarettes per day
- 16 to 25 cigarettes per day
- 26 to 35 cigarettes per day
- More than 35 cigarettes per day

FAMILY HISTORY OF CARDIOVASCULAR DISEASE (CV)

Place a "X" on the line that best describe your personal family history (blood relatives only)

- No known history of heart disease in family
- One relative over age 60 with CV Disease
- Two relative over age 60 with CV Disease
- One relative under age 60 with CV Disease
- Two relative under age 60 with CV Disease
- Three relative under age 60 with CV Disease

MUSCULOSKELETAL

Please describe any past or current musculoskeletal conditions you have incurred such as muscle pulls, sprains, fractures, surgery, back pain or general discomfort:

Head/neck: _____

Upper back: _____

Shoulder/clavicle: _____

Arm/elbow: _____

Wrist/hand: _____

Lower back: _____

Hip/pelvis: _____

Thigh/knee: _____

Lower leg/ankle/foot : _____

NUTRITIONAL

Are you on any specific food / nutritional plan at this time? Yes ___ No ___

If so, please list: _____

Do you take dietary supplements? Yes ___ No ___

If so, please list: _____

Do you experience any frequent weight fluctuations? Yes ___ No ___

If so, please list: _____

Have you experienced a recent weight gain or loss? Yes ___ No ___

If so, list change: _____ Over how long? _____

How many beverages do you consume per day that contains caffeine? _____

EXERCISE

Please check the box that best describes your work and exercise habits:

- Intense occupational and recreational exertion
- Moderate occupational and recreational exertion
- Sedentary work and intense recreational exertion
- Sedentary work and moderate recreational exertion
- Sedentary work and light recreational exertion
- Complete lack of all exertion

To what degree do you perceive your environment as stressful?

Signature of Client: _____ Date: ___/___/___

Signature of Witness: _____ Date: ___/___/___