

Release of Liability

1. In consideration of being allowed to participate in the personal fitness training activities and programs of Kim DeGeorge + PEAK PHYSIQUE and to use its facilities, equipment and services, in addition to the payment of any fee or charge, I do hereby forever waive, release and discharge Kim DeGeorge and its officers, agents, employees, representatives, executors and all others acting on their behalf from any and all claims or liabilities for injuries or damages to my person and/or property, including those caused by the negligent act or omission of any of those mentioned or others acting on their behalf, arising out of or connected with my participation in any activities, programs or services of Kim DeGeorge or the use of any equipment at various sites, including home, provided by and/or recommended by Kim DeGeorge (PLEASE INITIAL: _____)

2. I have been informed of, understand and am aware that strength, flexibility and aerobic exercise, including the use of equipment, is a potentially hazardous activity. I also have been informed of, understand and am aware that fitness activities involve a risk of injury, including a remote risk of death or serious disability, and that I am voluntarily participating in these activities and using equipment and machinery with full knowledge, understanding and appreciation of the dangers involved. I hereby agree to expressly assume and accept any and all risks of injury or death. (PLEASE INITIAL: _____)

3. I do hereby further declare myself to be physically sound and suffering from no condition, impairment, disease, infirmity or other illness that would prevent my participation in these activities or use of equipment or machinery. I do hereby acknowledge that I have been informed of the need for a physician's approval for my participation in the exercise activities, programs and use of exercise equipment. I also acknowledge that it has been recommended that I have a yearly or more frequent physical examination and consultation with my physician as to physical activity, exercise and use of exercise equipment. I acknowledge that either I have had a physical examination and have been given my physician's permission to participate or I have decided to participate in the exercise activities, programs and use of equipment without the approval of my physician and do hereby assume all responsibility for my participation in said activities, programs and use of equipment. (PLEASE INITIAL: _____)

4. I understand that Kim DeGeorge providing and maintaining an exercise/fitness program for me does not constitute an acknowledgment, representation or indication of my physiological well-being or a medical opinion relating thereto. (PLEASE INITIAL: _____)

Date: _____

Signature: _____

Trainer's Signature: _____

Personal Health History Form

General Information

Name		Today's Date			
Address		Home Phone		Work Phone	
City		State		Zip Code	
Occupation		Employer		Email Address	
Gender: Male Female	Date of Birth	Age	Current Weight	Height	

Emergency Information

Persons to be notified in case of an emergency:

Name	Relationship	Home	Work
Name	Relationship	Home	Work

Personal Physician

Doctor's Name	Specialty
Name of Clinic	Clinic Phone Fax
Clinic Address	City/State/Zip
May we contact your physician if questions or concerns arise regarding your health and exercise program? Yes No	

Family History

Have any of your primary relatives had any of the following conditions? Check all that apply.

- | | | | | |
|------------------------------------|--|---|---------------------------------------|---------------------------------------|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Angina | <input type="checkbox"/> Stroke | <input type="checkbox"/> Heart Attack |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Thyroid Disorder | <input type="checkbox"/> Obesity | <input type="checkbox"/> Other |

Please provide explanation for any items checked above.

Lifestyle Information

What is your profession?

How many hours do you work per week? (Circle one) <30 30 35 40 45 >45

What are the physical requirements of your job?

☐ Sitting ☐ Standing ☐ Phone ☐ Lifting ☐ Travel ☐ Other

Please rate your level of stress (0 = no stress 10 = very stressful) as work? _____ at home? _____

Please explain your job responsibilities.

Have you participated in a structured exercise program in the past?

☐ Yes ☐ No

Do you currently exercise on a regular basis?

☐ Yes ☐ No

If yes, how often do you exercise? (Circle one) 1x/week 2-3x/week 3-5x/week

Daily

Briefly explain your current exercise and recreational activities.

Has your doctor ever placed you on a special diet for medical purposes?

☐ Yes ☐ No

If yes, please explain.

Are you currently dieting?

☐ Yes ☐ No

If yes, please explain.

Do you drink alcoholic beverages?

☐ Yes ☐ No

If yes, how often? (Circle one) 1-3 3-5 5-8 8-10 10+ Drinks per week

Do you currently smoke cigarettes or use other tobacco products?

☐ Yes ☐ No

If yes, how often? Cigarettes per day: (Circle one) 1-5 5-10 10-15 15-20 20-25 25+

Are you a past smoker? ☐ Yes ☐ No If yes, when did you quit? _____

Health and Fitness Goals

What are your health and fitness goals? Check all that apply.

☐ Weight Loss

☐ Increase Cardiovascular Endurance

☐ Increased Strength

☐ Increased Flexibility

☐ Improved Posture

☐ Stress Management

☐ Increased Energy

☐ Performance Enhancement

☐ Other _____

Please identify any specific goals you have with respect to your exercise program.

Cardiorespiratory History

Please answer the following questions.

1. Do you experience any pain or discomfort in the chest at rest or with exertion?

☐ Yes ☐ No

2. Do you have a known heart murmur?

☐ Yes ☐ No

3. Do you have irregular heartbeats or arrhythmia?

☐ Yes ☐ No

4. Do you experience unexplained episodes of dizziness or fainting?

☐ Yes ☐ No

5. Do you have pain in the legs or arms at rest or during exercise?

☐ Yes ☐ No

6. Do you experience ankle edema?

☐ Yes ☐ No

7. Do you experience shortness of breath at rest or with mild exertion?

☐ Yes ☐ No

8. Do you experience unusual fatigue with daily or normal activities?

☐ Yes ☐ No

9. Do you smoke cigarettes or use other tobacco products?

☐ Yes ☐ No

Medical Conditions

Do you have asthma?

☐ Yes ☐ No

If yes, please explain.

Do you have diabetes?

☐ Yes ☐ No

If yes, please explain.

Do you have high blood pressure?

☐ Yes ☐ No

If yes, please explain.

Do you have high cholesterol?

☐ Yes ☐ No

If yes, please explain.

Do you have heart disease or any other heart problems?

☐ Yes ☐ No

If yes, please explain.

Have you ever been diagnosed with cancer?

☐ Yes ☐ No

If yes, please explain.

Do you have any past or current medical problems that may effect your ability to safely participate in an exercise program?

☐ Yes ☐ No

If yes, please explain.

Orthopedic History

Do you have any current or past orthopedic conditions (e.g. joint injuries, pain, surgeries) that may limit or effect your ability to exercise?

Neck ☐ Yes ☐ No

Wrist/Hand ☐ Yes ☐ No

Shoulder ☐ Yes ☐ No

Hip ☐ Yes ☐ No

Back ☐ Yes ☐ No

Knee ☐ Yes ☐ No

Elbow ☐ Yes ☐ No

Ankle/Foot ☐ Yes ☐ No

If yes to any of the above, please explain in detail.

Please explain all surgical procedures that you have had.

Medications

Please list all prescription and over-the-counter medications you currently use.

<i>Name of Medication</i>	<i>Purpose</i>	<i>Dose</i>
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<i>Name of Medication</i>	<i>Purpose</i>	<i>Dose</i>
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<i>Name of Medication</i>	<i>Purpose</i>	<i>Dose</i>
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Please indicate any food or drug allergies that you may have.

The information I have provided in this questionnaire is true and accurate to the best of my knowledge. I understand that this information is necessary for the purpose of developing a safe and effective exercise program. The information I have provided is to remain confidential. I agree to provide updated health information when it is relevant to the ongoing efficacy of my personal exercise prescription.

Signed

Date