SCULPT*MY*BODYFITNESS
BODY BOOT CAMP

Health Assessment & Registration: Small Group Fitness Training

Name: _____ DOB: _____ Age: _____

Address: _____ Website:_____

Phone: Home ( ) _____ Business ( ) _____ Email:_____

Emergency Contact/Relationship: _____ Phone: _____

Focused Group Fitness Package (5+ Persons): Start Date: _____.

____ 1 MONTH 4 Days/Week $115 _____ 1 MONTH 3 Days/Week $95 ____ 1 MONTH 2 Days/Week $70

____ 12 MONTHS Prepaid 4 Days/Week $1225

____ 12 MONTHS Prepaid 3 Days/Week $995 ____ 12 MONTHS Prepaid 2 Days/Week $799

*Make checks payable to Sculpt My Body Fitness. *Bring water, yoga mat, & fitness gloves to class.

Type of Payment: _____Visa/MC _____ Check _____ Cash Amount $ _____

Forms Completed: ____ Health Assessment ____ Par-Q _____ Participant Waiver/Release

Please check if applicable:

	Client	**Family**	**If yes, describe**
Recent Miscarriage	_____	_____	_____
Diabetes	_____	_____	_____
High Blood Pressure	_____	_____	_____
Angine/Chest Pain	_____	_____	_____
Heart Murmur	_____	_____	_____
Irregular Heart Beat	_____	_____	_____
Respiratory Infections	_____	_____	_____
Asthma	_____	_____	_____
Heart Attack	_____	_____	_____

Do you have any of the following conditions that may limit your physical activity?

____ Ankle/Foot Injury ____ Bone Fracture ____ Shoulder/Clavicle Injury
____ Low Back Pain ____ Wrist/Hand Injury ____ Arm/Elbow Injury
____ Knee/Thigh Injury ____ Head/Neck Injury ____ Hip/Pelvic Injury
____ Nerve Damage ____ Upper Back Injury ____ Other

If Other, please explain: _____

Please answer the following questions regarding your current exercise regimen:

SCULPTMYBODYFITNESS
BODY BOOT CAMP

1. Has your physician ever advised you against exercise? _____Yes ____ No

2. Are you presently receiving physical therapy? ____ Yes ____ No

3. Are you involved in an exercise program at the present time? _____ Yes ____ No
   If yes, please describe the program:
   _____

4. When exercising, including climbing stairs, do you ever experience: Chest pains, Shortness of Breath, Pressure over the Heart, Leg Aches or Dizziness? _____
   If yes, please explain:
   _____

5. What are your personal exercise program goals?
   _____ Weight Control/Loss _____ Staying in Shape _____ Stress Reduction
   _____ Increasing Strength _____ Cardiovascular Conditioning
   _____ Other
   If other, please describe:
   _____

I attest that the above information is true and correct to the best of my knowledge. I further affirm that the information collected on the health assessment form will ONLY be used for the purpose of initial interview and general fitness programming recommendations. None of these recommendations should be interpreted as replacing, supplementing or acting as medical advice. Sculpt My Body Fitness, LLC instructors, trainers, affiliates will NOT be responsible for knowing or using any of the information collected on this health assessment form.

_____ _____
Signature **Date**

I hereby affirm that I am exercising with my physician's approval regarding a fitness program and have read and fully understand the above agreement. I attest that I have read and understand the above.

_____ _____
Signature **Date**