

SCULPTMYBODYFITNESS

BODY BOOT CAMP

Health Assessment & Registration: Personal & Small Group Training

Name: _____ DOB: _____ Age: _____

Address: _____ Website: _____

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

Emergency Contact/Relationship: _____ Phone: _____

Personal/Small Group Package: Start Date: _____.

____ Initial Body Comp/Nutritional Consult \$45 ____ Program Design Fee \$55 (one time)

____ SINGLE SESSION Personal \$55 ____ SINGLE SESSION Small Group \$29/person
(2-3 persons)

____ 12 Session Pkg Personal \$550 ____ 12 Session Pkg Small Group \$675

*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:

	<u>Client</u>	<u>Family</u>	<u>If yes, describe</u>
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: _____

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Please answer the following questions regarding your current exercise regimen:

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