

IS Consult

Our mission is to create a safe environment in which all clients learn to improve their movement patterns and achieve greater levels of strength and physical conditioning. Through our commitment to ongoing staff education, we provide a comprehensive set of fitness solutions to empower clients to realize their potential.

I. Biographical Information

Client Full Name:		Nickname:
Mailing Address:		City, State Zip:
Date of Birth:	Occupation:	Preferred Email:
Mobile Phone:	Emergency Contact:	Emergency Contact Phone:
Home Phone:		
Primary Physician:	Physician Phone:	Date of Last Physical Exam:
Height:	Current Weight:	Approximate Weight 1 year ago: 5 years ago:
Do you exercise regularly?	If you exercise, how often?	Do you smoke?

II. Medical History

Physical Activity Readiness Questionnaire (PAR-Q)

	Question	Yes	No
1	Has your doctor ever said that you have a heart condition and that you should only perform physical activity recommended by a doctor?		
2	Do you feel pain in your chest when you perform physical activity?		
3	In the past month, have you had chest pain when you were not performing any physical activity?		
4	Do you lose your balance because of dizziness or do you ever lose consciousness?		
5	Do you have a bone or joint problem that could be made worse by a change in your physical activity?		
6	Is your doctor currently prescribing any medication for your blood pressure or for a heart condition?		
7	Do you know of <u>any</u> other reason why you should not engage in physical activity?		

If you have answered "Yes" to one or more of the above questions, consult your physician before engaging in physical activity. Tell your physician which questions you answered "Yes" to. After a medical evaluation, seek advice from your physician on what type of activity is suitable for your current condition.

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II. Medical History, cont.			
Circle any of the following for which you have been diagnosed, treated, or experienced symptoms and describe below:			
Alcoholism	Congenital defect	High Blood Pressure	Neck pain
Anemia (any form)	Diabetes	Hypoglycemia	Neurological disorder
Bleeding trait	Emphysema	Hyperlipidemia	Phlebitis
Bronchitis, chronic	Epilepsy	Joint pain or arthritis	Stroke
Cancer	Gout	Mononucleosis	Thyroid problems
Cirrhosis	Hearing loss	Kidney problems	Ulcer
Concussion	Heart problems	Mental illness	Other:
<i>Description(s):</i>			
List any surgeries you have had and the year each was performed:			
List all medications you are currently taking and their intended purpose			
Please describe below everything not already included in this medical history that might cause you problems in a fitness test or fitness program			

Client/Provider Agreement and Assumption of Risk

This Agreement is signed as of _____, 20____, by _____
 (“Client”) and INDUSTRIAL STRENGTH, INC. (“Provider”).

STATEMENT OF PURPOSE

Client desires to engage Provider to work with client in order to improve Client’s physical health through the implementation of a fitness regimen and, as appropriate, life style changes. Provider agrees to the engagement in reliance upon the following:

1. Health History Form. Client has or will complete a health history form provided to client by Provider.

2. Payment Terms. After the initial session, Client will pay for each session prior to its start unless other arrangements have been made. Sessions purchased by Client will expire sixty (60) days after payment for same unless Provider extends the 60 day period due to the physical impairment of Client.

3. Cancellation. Client will give Provider at least twenty-four (24) hours prior notice of any cancellation by Client. If such prior notice is not given, payment for the session will be expected. If Provider cancels a session without at least twenty-four (24) hours prior notice, Provider will make up the cancelled session free of charge.

4. Assumption of Risk. Client has obtained a release for exercise from Client’s Physician if deemed necessary by Provider. Client understands that there are risks involved in any exercise program. Client releases and holds harmless Provider, its employees and agents, from any loss or injury experienced by Client in connection with Client’s training except where the same is caused by the gross negligence of the Provider.

5. Diet Recommendations. Client understands that Provider is not a licensed or registered dietitian and the recommendations made by Provider to Client are based upon generally recognized dietary principles. If Client elects to use a dietitian associated with Provider, Client will release and hold harmless Provider and the dietitian from Client’s loss or injury growing out of dietitian’s advice except where the same is caused by the gross negligence of dietitian.

6. Undertakings of Client. Client takes full responsibility for Client’s health and well being. Client is encouraged to ask questions or request modifications to client’s exercise program, if necessary or desirable, at any time. Client agrees to stop any exercise that feels excessively uncomfortable or painful and to explain the circumstances to Provider promptly.

7. Client’s Commitment. Client understands that the program and advice received from Provider are not guaranteed to have the results desired by Client as such success rests greatly upon each individual and upon how faithful each individual adheres to the suggested program and recommendations. Client commits to pursue a positive and healthy lifestyle and to follow faithfully the program suggested in order to improve Client’s health and life.

INDUSTRIAL STRENGTH FITNESS

CLIENT

BY: _____

 (PLEASE PRINT NAME)