ADMIN USE ONLY: (rev. 3/15)
Referred or brought in by: _____
Inf. Consent signed Y N
Turned in to office: Y N
EZ Facility: Y N
IContact: Y N

HEALTH HISTORY and LIFESTYLE QUESTIONNAIRE

SECTION I (General Information)

Name: _____ Date: _____ Email: _____

Birth Date: (mm/dd/yy) _____Age: _____ Height: _____ Weight: _____

Street Address:_____ City:_____ State:_____ Zip:_____

Home Phone: _____ Work Phone: _____ Cell: _____

Primary Physician: _____ Phone: _____ Referred by: _____

In case of an emergency notify the following person(s):

Name:_____ Address:_____

Phone: (H)_____ (W):_____

SECTION II

Describe your primary reason for coming to us. If you primary reason include symptoms, please describe _____

_____

Do you have any functional limitations in your daily routine, work or recreational activities? If yes, describe: _____

_____

List your goals for training: 1. _____ 2. _____

_____ 3._____

If you have physical discomfort, pain or injury, please complete the following section. Circle words that best describe your symptoms:

Sharp	(or)	Ache
Tingling	(or)	Numb
Localized	(or)	Radiating
Constant	(or)	Variable
Pain	(or)	Stiffness

Please fill in all that are appropriate:

1. Where does it hurt? _____

2. Date symptoms first appeared: _____
3. Date of Injury: _____
4. Positions/activities that aggravate your symptoms: _____
5. Positions/activities that relieve your symptoms: _____
6. Time of day when symptoms are most apparent: _____

SECTION III (Medical Care)

When was your last physical exam?

_____

Check each applicable box for conditions you currently have (C) or have had in the past (P):

C	P		C	P		C	P	
☐	☐	anemia	☐	☐	depression	☐	☐	gout
☐	☐	arthritis	☐	☐	eating disorder	☐	☐	hemophilia
☐	☐	bursitis	☐	☐	epilepsy		☐	☐ HIV
☐	☐	cancer	☐	☐	fibromyalgia	☐	☐	hypoglycemia
☐	☐	cirrhosis	☐	☐	foot problems	☐	☐	lupus/other autoimmune
☐	☐	chronic fatigue	☐	☐	glaucoma			

If you have checked any of the above conditions, please describe below:

_____

_____

_____

1. Have any members of your immediate family (mother, father, sister or brother) been diagnosed with cardiovascular disease? ___ Yes ___ No
2. Have you ever been diagnosed with cardiovascular disease? ___ Yes ___ No
3. Do you ever experience an irregular or racing heart rate during exercise or at rest? ___ Yes ___ No
4. Do you or have you ever experienced chest pains? ___ Yes ___ No
5. Have you ever had a heart attack, coronary bypass, cardiac surgery, stroke? ___ Yes ___ No
6. Have you ever had an abnormal resting or stress EKG? ___ Yes ___ No
7. Do you have difficulty breathing or unusual shortness of breath? ___ Yes ___ No
8. Have you ever been diagnosed with pulmonary disease or pulmonary problems (asthma, emphysema, bronchitis)? ___ Yes ___ No
9. Have you ever experienced light-headedness or fainting? ___ Yes ___ No
10. Have you ever had or do you have high blood pressure? If yes, what is your blood pressure and is it controlled by medication? Please explain

    _____

    _____

11. Have you been diagnosed with Diabetes? If yes, what type and how is it being controlled?

_____

_____

SECTION IV (Medications)

List all medications you are currently taking:

Name	Frequency	For
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

SECTION V (Treatments)

List any hospitalizations, surgeries, physical therapy or chiropractic care:

Date	Age	Condition	Treatment	Outcome/Results
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

List any other health related practitioners you are currently seeing:

Name	Frequency	For
_____	_____	_____
_____	_____	_____
_____	_____	_____

SECTION VI (Lifestyle)

How do you spend most of your time at work?

_____ Sitting _____ Standing _____ Carrying loads _____ Driving _____ Walking

Do you smoke? _____

How many times per week do you engage in moderate or strenuous exercise for at least 30 minutes?

_____ 1 _____ 2 _____ 3 _____4 _____ 5 _____>5

Describe your energy level?

_____

PERSONAL TRAINING POLICIES

1. All clients will be charged for any training session(s) not cancelled 24 hours in advance. This excludes situations that are out of your control (i.e. weather, illness, etc.)
2. Payment for all training services should be paid per visit or on a weekly basis.
3. Clients should make all checks or payments to Training Partners, Inc.
4. Clients must complete all applicable form (informed consent, medical clearance, medical questionnaire, etc.) before training sessions can be initiated.

INFORMED CONSENT FORM

By signing this consent, I acknowledge that all information listed above is accurate and that I have voluntarily chosen to participate in a program of progressive physical exercise at Training Partners, Inc. Furthermore, I acknowledge being informed of the strenuous nature of the program and the potential for unusual, but possible, physiological results including but not limited to abnormal blood pressure, fainting, heart attack, or death. In addition, I assume all risk for my health and wellbeing and hold harmless of any responsibility, the instructor(s), facility (Training Partners, Inc.), trainer(s), or any person (s) involved with this program and testing procedures.

Client/Member Signature:_____ Date:_____

In case of an emergency notify the following person(s):

Name:_____

Address:_____ City, State:_____

Phone: (H)_____ (W):_____

CANCELLATION POLICY

Revised 3/2015

Dear Valued Client and Member:

Thank you for choosing us to assist you reach your health and fitness goals. We are excited to get you started but want to take a moment to explain our cancellation policy and answer any questions you might have.

First, we want to let you know that this policy is as important for you as it is for us. A strong cancellation policy keeps you accountable and ensures that you keep the commitment to yourself. The reality is that for most people, sticking with exercise can be difficult. It becomes easy to skip a workout if you're feeling a bit tired, stressed at work, or need to take care of some things at home. However, when clients know they will be charged for a session if they don't show up, it helps them to prioritize their health and fitness. This policy dramatically decreases no-shows, missed workouts, and short-notice cancellations which ensures better workouts and great results for you. We are the ones to make sure you do the things that sometimes you don't really want to do but know you need to do!

Second, a cancellation policy is important for us as a business. The average personal training studio can expect to experience a 25-40% cancellation rate of their weekly scheduled appointments. Many personal training studios have failed because of not understanding the nature of our business. The fitness industry is different from many other service industries in that most people do not enjoy exercise and often find convenient "excuses" to get out of or "skip" a workout. A massage therapist or hair stylist wouldn't have to enforce as firm a policy because few people want to miss their massage or haircut. These industries don't suffer from the high rate of cancellations that a personal training business does. You see, when you make an appointment with your trainer, we reserve that time for you. Your trainer spends time preparing for your session and some of our trainers drive quite a distance to be here for you. When a client cancels on short notice, it is very difficult (and many times impossible) for us to connect with another client who could possibly take that appointment. That time becomes lost and the revenues cannot be recovered.

We understand that things come up that may force clients to cancel unexpectedly (illness, work, home emergencies, etc.) and will work together to solve these cases as they arise. In the event of a short-notice cancellation, your trainer will use that time reserved to do something for you. For example, your trainer may research a health and nutrition topic of interest to you, design a new exercise program, or outline some exercises you can do at home. They may also use the time to brainstorm some new goals or pull together a report of your progress. You can also ask them to work on something specific for you during that time so it will not be money wasted.

We hope you understand that we regularly discuss this topic because we never want to institute policies that can potentially upset our clients. We recognize that we are in a difficult situation as a business - our number one priority is customer service, but at the same time, if we do not have a strict policy, our business and our clients do not succeed.

Thank you so much for your understanding. If you have any questions or concerns, please feel free to chat with any of us personally.

Yours in health and fitness,

Charlene and your Training Partners Team

Summary of Cancellation Policy

- Personal Training, Pilates Training and Small Group training sessions:
  Contact your trainer or SGT leader by 6pm the day before your training appt. or group training session.

I understand that Training Partners operates on a scheduled appointment basis for all Personal Training, Pilates Training and Small Group Training sessions and thus, requires that I cancel by 6:00pm the day before my Personal/Pilates or Small Group training session. Should I cancel a session after 6pm the day before my session, I will be charged for the missed session.

I understand that Training Partners recommends that all cancelled sessions be rescheduled to ensure consistency and success in my fitness progress.

_____ _____

Client Date

_____ _____

Trainer Date