



**General Information**

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_

Gender: \_\_\_\_\_

E mail: \_\_\_\_\_ Phone: \_\_\_\_\_

Emergency contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Primary physician: \_\_\_\_\_ Phone: \_\_\_\_\_

**Program goals:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Medical History**

Please indicate any present or past history of the following medical conditions by checking YES or NO. Use the available space to give details for YES answers.

YES	NO	Condition	YES	NO	Condition
_____	_____	History of heart attack, stroke, chest pain	_____	_____	Breathing or lung problems
_____	_____	Abnormal EKG or irregular heart beat	_____	_____	Epilepsy
_____	_____	Osteoporosis or osteopenia	_____	_____	Muscle, joint or back pain
_____	_____	Limitations or mobility restrictions	_____	_____	Hernia or condition that limits training
_____	_____	Pregnancy or recent birth	_____	_____	Smoke or having quit within 6 months
_____	_____	High blood pressure	_____	_____	Kidney or liver disease
_____	_____	Heart surgery	_____	_____	Increased blood cholesterol
_____	_____	Unexplained dizziness or fainting	_____	_____	Pain or swelling in the legs
_____	_____	Surgery	_____	_____	Circulatory problems
_____	_____	Joint replacement	_____	_____	Diabetes
_____	_____	Thyroid (low or high)	_____	_____	Sport or recreation injuries
_____	_____	ADD/ADHD	_____	_____	Anxiety/Depression/PTSD

If you answered YES to any of the above questions, please provide additional information below:

\_\_\_\_\_

\_\_\_\_\_

Please list any other medical conditions:

\_\_\_\_\_

Please list any medications you take:

\_\_\_\_\_

## Physical Activity History

Please list any fitness and recreational activities that you participate in regularly (how often, how hard and how long)

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Exercises that you would like to include in your exercise plan \_\_\_\_\_

Exercises that you would like to exclude from your exercise plan \_\_\_\_\_

Where do you plan to exercise? If at home, list all available equipment \_\_\_\_\_

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## Acknowledgment of Risk and Release

I have answered the questions in this intake form as accurately and completely as possible. I understand that this information is kept strictly confidential and cannot be released to any other party without my prior written approval in accordance with the Health Insurance Portability and Accountability Act of 1996. I understand that my failure to disclose health, medical or related information that might affect my participation in physical activity may limit the ability of the health/fitness professional to provide the safest possible physical activity program.

By registering yourself for participation in this program you will be:

- Acknowledging and assuming the risk of injury
- Waiving and releasing all claims for any injuries sustained that arise from participation
- Waiving and relinquishing all claims from participation against the City of Westminster and its officers, agents, servants, and employees from any and all claims by other parties resulting from injuries, damages and losses caused by me.
- Acknowledging that I have read and fully understand the above program details, waiver and release of all claims and shall not be modified orally.
- Acknowledging that I will be required to pay my personal training fee if I do not cancel any scheduled training sessions with my trainer with a 24 hour notice. Please initial \_\_\_\_\_.

**Participant Signature** \_\_\_\_\_ **Date:** \_\_\_\_\_