City of Westminster Client Intake Form

WESTMINSTER

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)

_____

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 _____

_____

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:** _____