EXPERIENCE THE DIFFERENCE

INNER CIRCLE

FITNESS

WWW.INNERCIRCLEFITNESS.COM

Contact Information

Name:_____

Home Address:_____

City:_____ State:_____ Zip:_____

Work Address:_____

City:_____ State:_____ Zip:_____

Telephone: Day:_____ Evenings:_____ Cell:_____

E-mail:_____

Date of Birth:_____

Occupation:_____

Emergency Contact:_____

Phone Number(s):_____ Other:_____

Relationship:_____

Liability Waiver

The undersigned recognizes that the use of Inner Circle Fitness services involve an inherent risk of physical injury including that caused by the negligence of the undersigned, Brad Worm, Inner Circle Fitness, or contractors and employees of Inner Circle Fitness. The undersigned hereby agrees to assume the risk of injury in its entirety regardless of the cause. Brad Worm, Inner Circle Fitness, and all contractors and employees of Inner Circle Fitness shall not be held liable for injuries or damages to the undersigned, or the property of the undersigned, or be subject to any claim, demand, injury, death, or damages whatever, including, without limitation, those damages resulting from acts of active or passive negligence on the part of Brad Worm, Inner Circle Fitness, and all contractors and employees of Inner Circle Fitness for all such claims, demands, injuries, death, damages, actions, or causes of action. It is specifically agreed that Brad Worm, Inner Circle Fitness and all contractors and employees of Inner Circle Fitness shall not be responsible or liable to the undersigned for articles lost or stolen in connection with Brad Worm, Inner Circle Fitness, or contractors and employees of Inner Circle Fitness's service.

Print Name:_____

Signature:_____

Date:_____

If under 18 years of age, please have parents/guardians sign here:

Print Name:_____

Parent(s)/Guardian(s) Signature:_____

Date:_____

Cancellation Policy

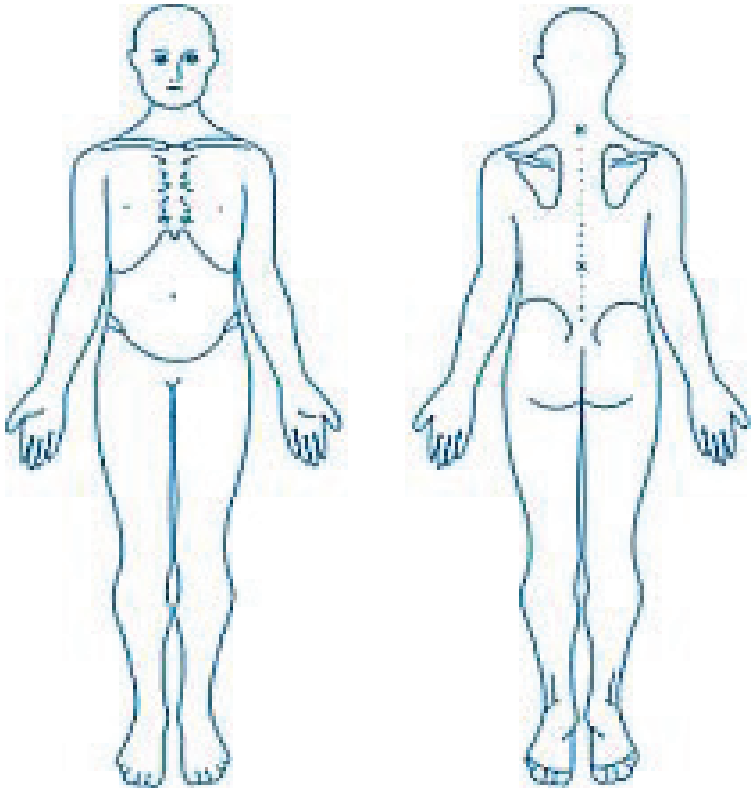
To give our staff advanced notice we do require 24 hour notice for any appointments that need to be cancelled. This insures you will not be charged for the session. All appointments cancelled within the 24 hour noticed are charged in full. Thank You.

Participants Signature:_____ Date:_____

If under 18 years of age, please have parents/guardians sign here:_____

Inner Circle Fitness Health History

Please indicate where on your body you have experienced problems.



Please describe each issue:

_____

_____

_____

_____

_____

HEALTH HISTORY

Name: _____

_____

Personal Physician: _____

Telephone: _____

Person to notify in case of an emergency: _____

Relationship: _____

Telephone: _____

MEDICAL HISTORY

Please check if you have had, or presently have, any of the following:

Heart/Vascular

- ❑ Chest pain/angina
- ❑ Heart palpitations/extra or skipped beats
- ❑ Blackouts/fainting spells/dizziness
- ❑ Swollen ankles
- ❑ Peripheral vascular disease/leg cramps/ cold hands or feet
- ❑ Heart attack/heart valve disease
- ❑ Coronary by-pass/cardiac surgery
- ❑ Pacemaker
- ❑ Heart murmur
- ❑ Abnormal electrocardiogram
- ❑ High blood pressure
- ❑ High cholesterol
- ❑ Stroke
- ❑ Phlebitis
- ❑ Varicose veins

Respiratory:

- ❑ Asthma/exercise-induced asthma
- ❑ Emphysema
- ❑ Chronic bronchitis
- ❑ Breathing difficulty/shortness of breath

Joint/Muscle:

- ❑ Arthritis/joint problems
- ❑ Disc problems
- ❑ Fractures
- ❑ Muscle pain/cramps/weakness
- ❑ Orthopedic problems
- ❑ Joint replacement
- ❑ Osteoporosis
- ❑ Other

Auto Immune Disease:

- ❑ Chronic Fatigue Syndrome
- ❑ Fibromyalgia
- ❑ AIDS/HIV
- ❑ Lupus

Neurological:

- ❑ Multiple Sclerosis
- ❑ Alzheimer's Disease
- ❑ Parkinson's Disease

Women Only:

- ❑ Currently pregnant
- ❑ Lactating
- ❑ Menopausal
- ❑ Post-menopause

Metabolic Disease:

- ❑ Diabetes, insulin dependent
- ❑ Diabetes, non insulin dependent
- ❑ Thyroid problems
- ❑ Other metabolic

Other:

- ❑ Paralysis
- ❑ Allergies
- ❑ Anemia
- ❑ Bleeding problems
- ❑ Cancer
- ❑ Epilepsy/seizures/convulsions
- ❑ Hernia
- ❑ Kidney or urinary tract disease
- ❑ Major surgery or hospitalization
- ❑ Mental health
- ❑ Overweight
- ❑ Rheumatic fever
- ❑ Stomach or bowel problems
- ❑ Chronic pain
- ❑ Eating disorders

Please explain any item which you checked and indicate the year of diagnosis or treatment: _____

_____

_____

Do you have any other physical limitations or medical conditions which should be considered before you begin an exercise program:

❑ Yes ❑ No If yes, please explain: _____

_____

_____

Date of last physical exam: _____

Have you had an electrocardiogram (ECG): Resting ❑ Yes ❑ No Exercise (treadmill) ❑ Yes ❑ No

Please list any prescription medications, self-prescribed medications, dietary or herbal supplements:

_____

_____

FAMILY HISTORY

Please check if any of your immediate family members (parents, grandparents, or siblings) have any of the following:

Heart disease Relationship: _____ Age of onset: _____
Diabetes Relationship: _____ Age of onset: _____
Osteoporosis Relationship: _____ Age of onset: _____
High blood pressure Relationship: _____ Age of onset: _____
High cholesterol Relationship: _____ Age of onset: _____
Cancer Relationship: _____ Age of onset: _____

LIFESTYLE HISTORY

Smoking history:
(including cigarettes, pipes and cigars):
Non-smoker ___
Ex-smoker __ packs/day __ years
Current smoker _____ packs/day years

Weight history:
Current weight _____ lbs
Weight 6 months ago _____ lbs
Highest adult weight _____ lbs
Lowest adult weight _____ lbs

Height history:
Highest adult height _____
Current height _____

PHYSICAL/ACTIVITY HISTORY

Do you have a regular exercise routine? ❑ Yes ❑ No
If yes, please list (walking, biking, strength training, etc...)

Activity: _____ times/per week: _____ duration: _____
Activity: _____ times/per week: _____ duration: _____
Activity: _____ times/per week: _____ duration: _____

Do you have any other sports, hobbies or recreational interest? (example: team sports, tennis, golf, gardening, etc.)

HEALTH/FITNESS INTERESTS

What activities are of interest to you?

❑ Stretching/relaxation
❑ Walking/jogging/running
❑ Balance & Stability
❑ Pilates
❑ Biking
  ❑ Stationary Biking
  ❑ Outdoor
❑ Strength
❑ Personal training
❑ Rowing
❑ Stairmaster
❑ Spa services
❑ Meditation
❑ Yoga
❑ Other activities

What are your other health goals:

❑ Stress Management ❑ Postural Improvement ❑ Social interaction ❑ Flexibility ❑ Endurance/Stamina
❑ Weight ❑ Nutrition ❑ Strength ❑ Balance & Stability

Other: _____
Is there any other information regarding your health/fitness goals you would like us to know? _____

Would you like us to send a copy of your physical assessment and testing to your physician: ❑ Yes ❑ No
Physician: _____
Mailing Address: _____
Phone: _____

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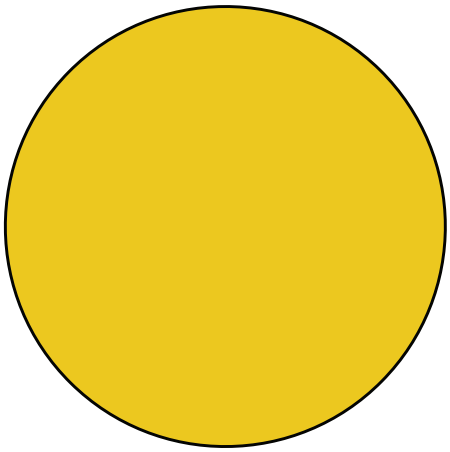
STRATEGY CIRCLE

Vision



Obstacles

Action

Transition

Vision **Obstacles** **Transition** **Action**

Needs Analysis and Lifestyle Questionnaire

The following information will help identify your exercise prescription and establish a base line from which to start. All questions are optional and your answers are held confidential and will not be released to anyone other than yourself.

Goals

Please rate your current fitness goals in each category that applies, 1 being the most important and a 5 being the least importance.

_____ General Health (blood pressure, lower cholesterol, increased energy etc)

_____ Weight Loss/Gain

_____ Appearance/Specific Areas of Your Body

_____ Pain Management

_____ Flexibility

_____ Strength

_____ Posture

_____ Job Performance

_____ Sports Performance

_____ Special Occasion (wedding, pregnancy, vacation)

How much time can you devote to your workout program?

Days/Week _____ Minutes/Day _____

What types of exercise interests you?

_____

_____

_____

Diet

Do you diet? Yes NO

If yes, why? Weight loss _____ Weight Gain _____ Medical _____

Do you feel your current diet is successful? Yes NO

What type of diet are you currently trying?

What types of diets have you tried in the past?

Were they successful or unsuccessful and why?

Do you currently or have you in the past suffered from an eating disorder?

Please describe your current typical eating habits.

Morning_____

Mid-Morning_____

Lunch_____

Mid-afternoon_____

Dinner_____

Evening_____

Estimated number of glasses of water consumed each day _____

Under what circumstances do you tend to overeat or eat foods you know you shouldn't?

_____

_____

Please list your current participation in physical activities, if any:

Activity	Times/Week	Minutes/Session
_____	_____	_____
_____	_____	_____
_____	_____	_____

What usually interrupts your workout Program?

_____

_____

How long do you usually stick with a workout program?

_____

_____

How many hours of sleep do you average per night? _____

Please rate your current life stress level (1-10; 10 being the highest) _____

What are you most looking for in a personal training program?

_____

_____

Please add any comments you wish:

_____

_____

_____

_____

IN•NER CIR•CLE

A small, intimate, and often influential
group of people with a common purpose.

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