

Personal Fitness Questionnaire – Chelsea Kmiec, Personal Trainer

Please complete, sign, and fax to 866-510-0925.

All faxes are delivered to a private email address and are kept completely confidential.

First Name: _____ Last Name _____
Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Email: _____
Work Phone: _____ Cell Phone: _____
Emergency Contact: _____ Phone _____
Gender: ___ Male ___ Female
Date of Birth ___/___/_____ Height: _____ Weight: _____

If known, what is your blood pressure? _____/_____

Personal Fitness

Presently, do you exercise on a regular basis? Yes ___ No ___

If yes, describe the exercise routine:

How many days per week do you exercise? _____

How many minutes each day? _____

How long have you been exercising regularly? _____ years _____ months

Are you at your ideal weight? _____ if no, what is your ideal weight? _____

What is the most you have weighed as an adult? _____ lbs.

What is the least you have weighed as an adult? _____ lbs.

What goals would you like to achieve through your exercise program?

Assign a number 1 through 5 to rate the following statements.

(1 represents the lowest level, 5 represents the highest level)

Please give your perception of the following:

How fit you currently feel

___ 1 ___ 2 ___ 3 ___ 4 ___ 5

The discipline you have to maintain a consistent workout routine

___ 1 ___ 2 ___ 3 ___ 4 ___ 5

Your capacity for aerobic activity

___ 1 ___ 2 ___ 3 ___ 4 ___ 5

Your muscular strength

___ 1 ___ 2 ___ 3 ___ 4 ___ 5

Your body's ability to recover

___ 1 ___ 2 ___ 3 ___ 4 ___ 5

Your daily energy level

___ 1 ___ 2 ___ 3 ___ 4 ___ 5

How much time will you devote to an exercise program?
_____ days per week _____ minutes per day

What types of exercises do you most enjoy?

What types of exercises do you least enjoy?

Diet and Nutrition

How would you describe your diet?
____ unhealthy ____ erratic ____ healthy

What would you like to change about your diet?

Are you willing to change your diet? _____
What is the greatest challenge you face with your nutrition? _____

How many meals, on average, do you eat each day? _____ meals per day

What are you most proud of about your eating habits?

What are you least proud of about your eating habits?

Medical History

Are you currently under a doctor's care? ____ yes ____ no
If yes, explain:

When was the last time you had a physical examination (mm/dd/yy)?

Have you ever had an exercise stress test? ____ yes ____ no
Have you recently been hospitalized? ____ yes ____ no
If yes, explain:

Do you smoke? ____ yes ____ no
Are you pregnant? ____ yes ____ no
Do you drink alcohol more than three times per week? ____ yes ____ no
Do you consider your stress level to be high? ____ yes ____ no

Have you ever been diagnosed with any of the following, put an X on all that apply.

<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	Irregular heart beat or palpitations
<input type="checkbox"/>	High cholesterol	<input type="checkbox"/>	Lightheadedness or fainting spells
<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Unusual shortness of breath
<input type="checkbox"/>	Known heart disease	<input type="checkbox"/>	Cramping or numbness in your legs or feet
<input type="checkbox"/>	Heart murmur	<input type="checkbox"/>	Emphysema
<input type="checkbox"/>	Chest pain during activity	<input type="checkbox"/>	Chronic headaches
<input type="checkbox"/>	Blurred vision	<input type="checkbox"/>	Thyroid or kidney disorders
<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Arthritis

Do you have any other injuries or pain? yes no
 If yes, describe:

Please list any surgeries you have had _____

Do you have a grandparent, parent, or sibling who, prior to age 55 has had:
 a heart attack? yes no
 a stroke? yes no
 high blood pressure? yes no
 high cholesterol? yes no
 Weight (obesity) problems? yes no

By Signing below, I verify that all of this is correct to the best of my knowledge. I also accept the 24 hour cancellation policy of all scheduled personal training sessions with Chelsea Kmiec.

Signed: _____ Date: _____

24 HOUR CANCELLATION POLICY

All appointments not cancelled within 24 hours will result in a charge equal to the full amount of that session.

Waiver of Liability, Indemnity Agreement, and Assumption of Risk

Waiver: In consideration of permission to participate in activities and programs as directed by *Chelsea Kmiec*, today and on all future dates, I on behalf of myself, my heirs, personal representatives, or assigns, do hereby release, waive, discharge, and covenant not to sue, *Chelsea Kmiec*, her directors, officers, employees, volunteers, independent contractors, and agents from liability from any and all claims arising from the ordinary negligence of *Chelsea Kmiec* or any of the aforementioned parties. This agreement applies to 1) personal injury (including death) from accidents or illnesses arising from the participation in personal training activities including, but not limited to, organized activities, aerobic activities, classes, weight lifting, muscle activation techniques, and individual use of facilities, premises, or equipment; and to 2) any and all claims resulting from the damage to, loss of, or theft of property.

Indemnification and Hold Harmless: I agree to HOLD HARMLESS AND INDEMNIFY *Chelsea Kmiec* from all claims resulting from negligence and to reimburse for any expenses incurred by *Chelsea Kmiec* in investigating and defending a claim or suit if my claim is withdrawn, or to the extent a court or arbitration determines that *Chelsea Kmiec* is not responsible for the injury or loss.

Acknowledgement of Understanding: I have read this waiver of liability and indemnification agreement and fully understand its terms. I understand that I am giving up substantial rights, including my right to sue. I acknowledge that I am signing the agreement freely and voluntarily, and intend my signature to be a complete and unconditional release of all liability to the greatest extent allowed by law in the State of Illinois.

Signature of Client

Date

Assumption of Risks: Physically activity, by its very nature, carries with it certain inherent risks that cannot be eliminated regardless of the care taken to avoid injuries. Chelsea Kmiec has facilities for and provides for activities such as weight lifting, walking, jogging and running, and aerobic activities. Some of these involve strenuous exertions of strength using various muscle groups, some involve quick movements involving speed and change of direction, and others involve sustained physical activity, which places stress on the cardiovascular system.

The specific risks vary from one activity to another, but in each activity the risks range from 1) minor injuries such as scratches, bruises, and sprains to 2) major injuries such as loss of sight, joint or back injuries, concussions, and heart attacks to 3) catastrophic injuries including paralysis and death.

I have read the previous paragraphs and I know the nature of the activities that may be recommended to me by Chelsea Kmiec at Symmetry Center, or any other facility in which he provides personal training services, I understand the demands of those activities relative to my physical condition and skill level, and I appreciate the types of injuries, which may occur as a result of those activities. I hereby assert that my participation is voluntary and that I knowingly assume all such risks.

Acknowledgement of Understanding: I have read this assumption of risk and fully understand its terms. I acknowledge that I am signing freely and voluntarily and intend my signature to signify a complete assumption of the inherent risks of participating in any and all personal training activities with Chelsea Kmiec to the greatest extent allowed by law in the State of Illinois.

Signature of Client

Date