



Client Information

Perfect | Forms

First and Last Name _____ E-mail Address _____

Mailing Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Which number do you prefer we use if we need to contact you? _____

Emergency Contact _____ Phone _____

How did you hear about us? _____

Have you ever had a professional massage? _____ Have you ever had personal training? _____

Medical History

Please check any of the following health risks and medical conditions that you have had in the past or currently have. If you need to note something that is not mentioned please note it in the other medical conditions area below:

- | | | |
|---|---|--|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Arteriosclerosis (hardening of the arteries) | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Previous heart attack (please add details)* |
| <input type="checkbox"/> Arthritis (please add details in box)* | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Previous stroke (please add details)* |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Previous surgery (please add details)* |
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Headaches/Migraines | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Bruising | <input type="checkbox"/> Heart problems (please add details)* | <input type="checkbox"/> Sensitive skin |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High blood pressure (even if controlled with meds) | <input type="checkbox"/> Sinus problems |
| <input type="checkbox"/> Carpal Tunnel Syndrome | <input type="checkbox"/> High cholesterol (even if controlled with meds) | <input type="checkbox"/> Sleep difficulties |
| <input type="checkbox"/> Chronic pain | <input type="checkbox"/> Hip/Back Pain | <input type="checkbox"/> Sprains/Strains |
| <input type="checkbox"/> Contagious Conditions (please add details)* | <input type="checkbox"/> Hyper thyroid | <input type="checkbox"/> Swelling |
| <input type="checkbox"/> COPD (chronic obstructive pulmonary disease) | <input type="checkbox"/> Hypo thyroid | <input type="checkbox"/> TMJ |
| <input type="checkbox"/> Coronary artery disease | <input type="checkbox"/> Pregnant | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Other (please add details)* |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Low Blood Pressure | |
| <input type="checkbox"/> Digestive Disorders | <input type="checkbox"/> Numbness | |

Details (use back of paper as needed):

Client Name _____



Personal Training Clients

Perfect | Forms

For your protection, if you have any of the conditions listed below, I ask that you please supply a letter of clearance from your physician to receive personal training.

- | | |
|---|--|
| <input type="checkbox"/> Autoimmune disorders | <input type="checkbox"/> Recent major injury and/or surgery |
| <input type="checkbox"/> Fever | <input type="checkbox"/> Cardiovascular Disease / Heart Attack |
| <input type="checkbox"/> Infectious Conditions: ringworm, scabies, infectious diarrhea, flu, etc. | <input type="checkbox"/> Unexplained Chest Pain |
| <input type="checkbox"/> Sickle cell disease (during acute stage) | <input type="checkbox"/> Advanced Osteoporosis |

Do you have any other current health condition(s) that would limit your ability to participate in personal training or need any special accommodations? _____ If yes, please explain. _____

By initialing here, you attest that you have no current health problems that would limit your ability to participate in personal training: _____

On a typical day do you do a lot of (circle): Sitting, Standing, Bending, Lifting, Repetitive Movements
Do you participate in a regular exercise program at this time? _____ If yes, please describe. _____

Have you performed resistance training exercises in the past? _____ If yes, please describe. _____

Do you smoke? _____ If yes, how much per day and at what age did you start? _____

Please list any medications and/or supplements you are taking. _____

What is your body weight now? _____ What was it a year ago? _____ What was at age 21? _____

In general how do you feel about your weight/body image? _____

Do you follow or have you recently followed any specific dietary intake plan? In general how do you feel about your nutritional habits? _____

Client Name _____



Personal Training Clients (cont.)



Waiver: I (the client) do hereby state that the above information is true and complete to the best of my knowledge and that I will not hold Perfect Forms Massage and Personal training or any trainer thereof liable for any mishaps or injuries (physical or otherwise) arising from my training. I acknowledge that my choice to participate in training sessions is my complete personal responsibility, and such participation is at my own risk. I understand that it is my responsibility to report to my trainer any changes to the information listed above. I understand that if I experience any unusual discomfort and/or pain during my training it is my responsibility to inform the trainer so that he/she can adjust my program. On behalf of myself and all others in legal relationship with me, I hereby release Amy Walter and Michael Welch, Perfect Forms Massage and Personal Training, and all affiliates from any and all liability for any injury, emotional or physical, which may occur while I am a client at Perfect Forms or as a result of using any information or instructions I receive from them or any Perfect Forms affiliates. I declare that I have read, understood, and agreed to the contents of this waiver in its entirety.

Client Signature _____ Date _____
Perfect Forms Employee Signature _____ Date _____

Personal Training Goal Setting

Only you can determine what constitutes a successful personal fitness program. This form will help us understand the goals and priorities you are setting for yourself.

1. Rank the following using a scale of 1 to 5.

Table with 6 columns (Ranking scale 1-5) and 10 rows (flexibility, strength, pain relief, stress management, stamina/endurance, weight management, better sleep, athletic performance, work performance, other).

2. Have you ever worked with a personal trainer before? What did you enjoy/not enjoy? Was it successful? If not, why? _____

Blank lines for answer to question 2.

3. Please state your present fitness and health goals in your own words. Feel free to elaborate. _____

Blank lines for answer to question 3.

Client Name _____