540 Lake Center Parkway
Suite 101
Cumming GA, 30040
Phone: (678) 200-0445
Fax: (770) 205-1312
www.focalfitnesscenter.com

MEDICAL HISTORY QUESTIONNAIRE

Name _____Date ___/___/___

Home Address _____

Home Phone_____

Work Address_____

Work Phone _____

E-mail_____

Age _____ Date of Birth ____ / ____ / ____ Sex _____ Height _____ Weight _____

General Medical History:

CIRCLE ONE

1. Do you currently have any medical complaints? _____ Yes No Date
   _____
2. Have you ever been hospitalized, treated for serious illness, or had surgery? If yes, please explain. _____ Yes No _____
   _____
3. Have you had major surgery or an injury that might hinder or prohibit participation in an exercise program? If yes, please explain. Yes No _____
   _____
4. Are you currently under a physician's care for any physical health problem?_____ Yes No
   If yes, please explain: _____
5. Are you aware of any problems that would keep you from participating in regular, vigorous physical activity.
   Yes No
   If yes, explain: _____

6. Are you presently taking any medication (prescription and non-prescription)? Yes No

Medication	Dose	Reason for taking	For how long?

7. Do you have, have you recently experienced, or have you ever had (check those applicable):

- o rheumatic fever
- o high cholesterol
- o high blood pressure
- o infections
- o aneurysm
- o asthma
- o embolism
- o stroke
- o diabetes
- o edema/swelling
- o pneumonia
- o increased anxiety
- o emotional disorder
- o trouble sleeping
- o knee problems
- o lightheadedness, fainting or dizziness
- o respiratory discomfort
- o fixed rate pacemaker
- o emphysema
- o bronchitis
- o depression
- o low blood pressure
- o valve disease
- o rapid heart beats or irregular heart beats
- o disordered eating
- o migraine
- o back problems
- o foot problems
- o disease of arteries
- o abnormal lack of energy
- o arthritis
- o neck problems
- o hernia
- o bursitis
- o broken bones
- o heart attack
- o heart medications
- o stomach problems
- o limited movement in joints
- o shoulder problems
- o ulcers
- o anemia
- o heart murmur
- o thromgophlebitis
- o angina/chest pain/discomfort
- o epilepsy/seizure
- o shortness of breath

8. Do any of your immediate family/grandparents have a history of (check those applicable):

- o heart disease
- o heart surgery
- o high cholesterol
- o diabetes
- o heart attack
- o congenital heart disease
- o high blood pressure
- o stroke
- o premature death

If yes, please note relationship and age_____

Weight History (this will remain confidential between you and your trainer)

9. One year ago _____ Today _____ Maximum Ever _____

Smoking History Ever Yes No

10. How long since you quit? How many cigarettes/day? Now Yes No #_____

Nutrition History

11. Do you drink caffeinated coffee or colas? ___Yes ___No If yes, how many per week_____

12. Are you now or have you ever been on a diet? ___Yes ___No If yes, please explain:
_____

13. Do you consider yourself overweight? ___Yes ___No Do you consider yourself underweight? ___Yes ___No

14. Number of meals you usually eat per day:____

15. Do you usually eat breakfast? ___Yes ___No

****I have read, understood and completed this questionnaire. To the best of my knowledge, the above information is true. I understand that if my health changes in such a way as to limit my exercise capacity, I will tell my fitness professional.***

Signature: _____ Date:_____

****All information is kept confidential.****

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WELLNESS & LIFESTYLE QUESTIONNAIRE

Name:_____ **Date:** _____

E-mail:_____ **Phone:** _____

1. What are your goals as they pertain to health, wellness, and fitness? (example: Gain strength, lose weight, become more flexible, gain balance)

2. What is your current activity level? _____ min/day _____ day/week

3. What days and time of day are you available for exercise? Please circle all options below:

Monday	5am-9am	9am-1pm	1pm-5pm	After 5pm
Tuesday	5am-9am	9am-1pm	1pm-5pm	After 5pm
Wednesday	5am-9am	9am-1pm	1pm-5pm	After 5pm
Thursday	5am-9am	9am-1pm	1pm-5pm	After 5pm
Friday	5am-9am	9am-1pm	1pm-5pm	After 5pm
Sat/ Sun	5am-9am	9am-1pm	1pm-5pm	After 5pm

4. What activities do you do?

_____

5. How much time are you willing to devote to an exercise program? ____min/day ___day/week

6. Would you prefer a Male/Female personal trainer. Please circle all preferences below:

Male Female No Preference

7. What types of activities interest you most? Please check all that apply.

_____ Walking and/or jogging	____ Stationary cycling	____ Gardening
_____ Weight training	____ Golf	____ Yoga
_____ Swimming	____ Tennis	____ Hiking
_____ Cycling (outdoors)	____ Aerobic class	____ Other(_____)

8. **If you have attempted a regular exercise program before, what would you describe as your greatest roadblock to consistency?**

9. Is there anything else you would like your personal trainer to know about you or your habits?

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Personal Training
Waiver and Assumption of Risk

Waiver and Assumption of Risk: I,_____, in consideration of being permitted to participate in physical activity in the Focal Fitness Personal Training Program and to use its equipment and facilities, on behalf of myself, my family, my heirs, and my assigns, **I hereby release Focal Fitness, and each of their respective employees,** from any and all liability for injury, death, negligence or negligence of a third party, property loss or damage suffered by me as a result of my participation in the program, or my use of the facilities and its equipment, or any way associated with my participation in any and all program activities now or in the future.

I, _____, acknowledge that I know, understand, and appreciate the inherent risks of participating in this program, using the facilities or the equipment and of participating in the Focal Fitness Personal Training Program. **I know that these risks may include, but are not limited to minor scrapes, strains, and bruises, as well as significant injuries such as broken bones, eye injury or loss, concussions, paralysis, and even death.** By execution of this agreement, I fully assume the inherent risks associated with the Focal Fitness Personal Training Program and assert that I am voluntarily participating in such activities. I understand that by signing below, that my personal information will be shared with my potential and or specific trainers for the purpose of their training services only. I have read this release of liability, fully understand it, freely and voluntarily sign the same, and I am acting for myself, my heirs, personal representatives and assigns.

Signature:_____
(your signature)

Address:_____
(street) (city/state) (zip)

NOTE: IF YOU ARE LESS THAN EIGHTEEN YEARS OLD, YOUR PARENT OR LEGAL GUARDIAN ALSO MUST SIGN BELOW:

Signature:_____
(Parent/Legal guardian signature)

Address:_____
(street) (city/state) (zip)

Date:_____

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Client – Trainer Agreement Form

1. I understand that I need to pay for my personal training sessions prior to our first session.
2. I understand that I need to give my trainer 24 hours notice if I need to cancel or reschedule a session. If I do not contact the trainer within 24 hours of my scheduled session to cancel, I will be charged for that session.
3. I understand that if I do not show up for a session, I will be charged for the full price of that session.
4. I understand that my trainer will wait up to 15 minutes if I am late and the session will still end at the scheduled time.
5. I understand that I need to eat well and drink plenty of water before each personal training session.
6. I understand that I need to vocalize any pain or illness I am feeling prior, during, and after the session.
7. I understand that the training environment is up-close and personal and I need to be courteous to my trainer with good overall hygiene.
8. I understand that I need to wear proper workout attire.

Client signature: _____ Date:_____

Trainer signature:_____ Date:_____