PILATES/YOGA LIFESTYLE PROFILE

Please complete the following information as accurately and fully as possible. This will help your instructor assess your overall health and individual needs completely in order to design the most beneficial plan for you and your body. All information is kept confidential.

For your 55-minute appointment, please bring this profile with you, and wear comfortable athletic clothing and athletic shoes *(although most of the work is done without shoes).* Should you need to cancel, a 24-hour notice is required to avoid being charged the full session amount.

We look forward to being partners in your journey toward health and well-being.

GENERAL INFORMATION

Name (Last) *First* *(MI)*

Home Address

City *State* *Zip*

Phone (Day) *(Evening)* *(Cell)*

If we may contact you by e-mail, please provide your e-mail address: _____

☐ *Male* ☐ *Female* *Age:* _____ *Date of Birth:* ____ /____ /____

Emergency Contact *Phone*

Physician *Phone*

OVERALL HEALTH

Has a doctor or health professional ever told you that you have any of the following conditions?

☐Heart Disease** ☐Diabetes**
☐Family history of heart disease ☐Lack of physical activity
☐High Blood Pressure ☐Obesity
☐High Cholesterol

What is your current smoking status?

☐I have never smoked or quit more than 6 months ago.
☐I currently smoke or quit within the last 6 months.

Have you ever been diagnosed with cancer?
☐Yes** ☐No
If so, when and what kind?_____

Are you pregnant, or have you had a child in the past eight weeks? ☐Yes** ☐No

Please list any major surgeries you've had:

_____

_____

Are you currently taking medications for any of the following:

☐Blood Pressure ☐Heart
☐Cholesterol ☐Other Medication(s)
☐Blood Sugar Please list: _____

_____

Do you have or have you had any of the following that could be made worse by a change in your physical activity?

☐Back Pain ☐Spinal Injury
☐Bone, joint, tendon, or muscular pain
☐Lung disease *(asthma**, emphysema, or shortness of breath)*
Please explain:_____

_____

FITNESS

How many times per week do you exercise?
☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7

Briefly describe the type of exercise or activities you regularly participate in:
Cardiovascular: _____

Strength training: _____

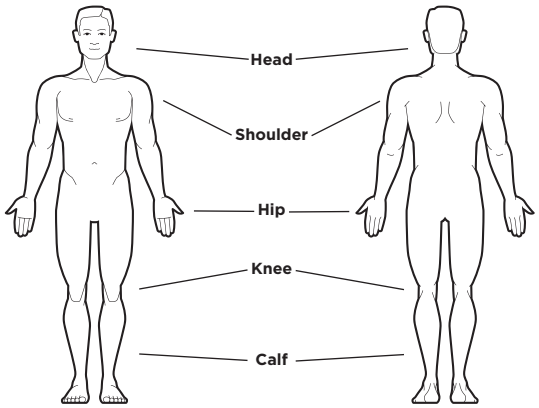
Flexibility/Stretching: _____

What would you like to change the most? *(check all that apply)*

☐Energy/Stamina ☐Flexibility ☐Appearance ☐Well being

☐Posture ☐Stress Level ☐Other _____

Please circle any and all areas of pain, tightness or discomfort:



INFORMED CONSENT FOR EXERCISE PARTICIPATION

Exercise Participation. I desire to engage voluntarily in an exercise program with a personal trainer in order to attempt to improve my physical fitness. I understand that the activities are designed to place a gradually increasing workload on my cardiorespiratory and musculoskeletal systems and to thereby attempt to improve their function.

Risks and Discomfort from Exercising. During cardiovascular exercise including cardiovascular testing, certain changes may occur. These changes include abnormal blood pressure responses, fainting, irregularities in heartbeat, and heart attack. Every effort is made to minimize these occurrences. During muscle fitness and flexibility testing, as well as strength training and stretching, there is a slight possibility of straining a muscle or spraining a ligament. In addition, muscle soreness may also be experienced 24 to 48 hours after testing. Appropriate stretching exercises will be demonstrated to alleviate muscle soreness should it occur.

Freedom of Consent. I have read this form carefully and I fully understand the test procedures. I consent to participate in these tests and/or the exercise program. *(Permission to perform these fitness tests is voluntary. You are free to deny consent if you so desire.)*

WAIVER AND RELEASE OF LIABILITY *(Read carefully before signing!)*

- I am aware that PRO Sports Club personal trainers are not medical doctors and are not qualified to determine a participant's physical capability to engage in strenuous exercise.
- The information given on this medical history questionnaire is correct to the best of my knowledge. I understand that absence of the physical problems listed on this form does not necessarily guarantee that I am in satisfactory health to participate in PRO Sports Club activities.
- Medical clearance from my physician may be required prior to participation in the exercise program. I agree to allow PRO Sports Club to consult my physician and obtain written permission as needed. If my condition or medication changes, I will inform my trainer.

(Read carefully before signing!) I agree that this Waiver and Release of Liability shall apply to each visit I make to PRO Sports Club, including future visits, regardless of any date of issuance or expiration date on the Guest or Permanent membership card, and regardless of the date that this form is signed below. I understand and acknowledge there is risk involved in being in and around PRO Sports Club's facilities, including, but not limited to, utilizing equipment or participating in any exercise or fitness activity. In consideration for being allowed to utilize PRO Sports Club's facilities, I agree I will assume the risk and full responsibility for any and all injuries, losses, death, costs, or other damages, that might occur to me and/or to my family while on the premises of PRO Sports Club or participating in any off-site PRO Sports Club program or activity; and to the maximum extent allowed by law, I agree to waive and release any and all claims, suits, or related causes of action against Professional Recreation Organization, Inc., its owners, officers, employees, or agents (collectively PRO Sports Club), for negligence, injury, loss, death, costs, or other damages to me, my heirs or assigns, while on the premises of PRO Sports Club or participating in any off-site PRO Sports Club program or activity. I further agree I will indemnify, defend and hold PRO Sports Club harmless, to the maximum extent allowed by law, from negligence, injury, loss, death, costs, or other damages to me, my heirs or assigns, or third parties for claims, suits, or related causes of action asserted against PRO Sports Club arising from my conduct and/or my family's conduct while on the premises of PRO Sports Club or participating in any off-site PRO Sports Club program or activity and this waiver and release shall bind the members of my family and my spouse or registered domestic partner, if I am alive, as well as my estate, family, heirs, administrators, personal representatives or assigns if I am deceased, and shall be deemed as a "Release, Waiver, Discharge and Covenant" not to sue PRO Sports Club. I further agree to release, indemnify, defend and hold PRO Sports Club harmless from any liability whatsoever for future claims presented by my children or any other minor children and/or their parents, whose visit to PRO Sports Club is sponsored by me, for any injuries, losses or damages to themselves or any family member or registered domestic partner. If any term of this waiver and release shall be found illegal, unenforceable or in conflict with any applicable law, the validity of the remaining portions shall not be affected thereby.

I have read this waiver and release of liability. _____ Initials

CANCELLATION POLICY

- A 24-hour notice is required to avoid a full session charge for all personal training sessions. This includes illness or sickness. Rates may increase periodically. Packages and periodic promotions do expire. I agree to pay for all scheduled personal training services charged to my PRO Sports Club account. I understand and agree to these terms. _____Initials

BY MY SIGNATURE BELOW I UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS.

Print Name: _____ *Signature:* _____ *Date* _____

Parent/Guardian Name: _____ *Signature:* _____ *Date* _____
(If under 18 years, parent or guardian signature required)

Witness _____ *Signature:* _____ *Date* _____
(PRO Sports Club staff, please print)

FOR MEDICAL USE ONLY (RISK STRATIFICATION):

☐**Low Risk:** Asymptomatic 0-1 risk factors

☐**Moderate Risk:** Asymptomatic 2+ risk factors. Medical clearance recommended for exercise.

I understand I am advised to get medical clearance before engaging in exercise._____Initials

☐****High Risk:** 1+ major sign or symptom, or known disease-cardiac disease, peripheral vascular disease, COPD, asthma, interstitial lung disease, cystic fibrosis, diabetes type I or II, thyroid disorders, renal or liver disease. Medical clearance required for supervised exercise.

I understand to engage in supervised sessions with a PRO Sports Club instructor that I first need medical clearance._____Initials