

## Sharp Physiques Fitness Center Health Questionnaire and Assumption of Risk

Please fill out this form accurately – it is essential for your safety.

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Work Phone: \_\_\_\_\_ Mobile/Home Phone: \_\_\_\_\_  
 Email: \_\_\_\_\_  
 Occupation: \_\_\_\_\_

Known Diagnosis, if any \_\_\_\_\_

Do you have or have you ever had:	<u>Yes</u>	<u>No</u>	<u>Explain</u>
Have you ever been hospitalized	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Attack or Heart trouble	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chest Pain or Angina Pectoris	<input type="checkbox"/>	<input type="checkbox"/>	_____
Coronary Bypass or Angioplasty	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Murmur – Noted by a physician to be significant or suggestive of a heart abnormality	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure above 145/95	<input type="checkbox"/>	<input type="checkbox"/>	_____
Impaired Circulation	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	_____
Convulsions or loss of consciousness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes Mellitus	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Cholesterol Level	<input type="checkbox"/>	<input type="checkbox"/>	_____
Are you pregnant	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you smoke or have you ever smoked or used smokeless tobacco for a total of 5 years or more	<input type="checkbox"/>	<input type="checkbox"/>	_____
Musculoskeletal Limitations of Movement	<input type="checkbox"/>	<input type="checkbox"/>	_____
Difficulty of breathing/shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis, Rheumatism	<input type="checkbox"/>	<input type="checkbox"/>	_____
Knee Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
A chronic, recurring morning cough	<input type="checkbox"/>	<input type="checkbox"/>	_____
Any episode of coughing up blood	<input type="checkbox"/>	<input type="checkbox"/>	_____
Increased anxiety or depression	<input type="checkbox"/>	<input type="checkbox"/>	_____
Swollen, stiff, or painful joints	<input type="checkbox"/>	<input type="checkbox"/>	_____
Back Pain (herniated or ruptured disc)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Shoulder Pain	<input type="checkbox"/>	<input type="checkbox"/>	_____
Surgery	<input type="checkbox"/>	<input type="checkbox"/>	_____

I, \_\_\_\_\_ (hereafter "Client") on this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_, acknowledge that I fully understand the risk of my participation in the Sharp Physiques personal training program and I assume full responsibility for my decision to participate.

I acknowledge that I have been advised to obtain my physician's release prior to my participation.

Therefore, I indemnify and agree to hold harmless Sharp Physiques' owners, personal trainers, management, agents, servants, employees, directors, and subsidiaries from any and all claims, actions, demands, costs, liabilities, expenses and judgments whatsoever, including attorney's fees and costs which might arise in any manner from my participation in the Sharp Physiques personal training program.

\_\_\_\_\_  
Client Signature- Parent/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Sharp Physiques Representative

\_\_\_\_\_  
Date