



CLIENT INFORMATION SHEET

Please note that all information is strictly confidential.

Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. Here at this office we offer Chiropractic, Massage, Aesthetics, Yoga, Pilates, Ball Core Strength Training & Weight Toning; this health information can be used for any and all of the above. If we believe that we cannot assist you with your health care needs, we will be more than happy to refer you to the appropriate health care professional. If you have any questions, please ask. Thank you.

First Name: _____ Middle Initial: _____ Last Name: _____

Date of Birth: ____ / ____ / ____ Age: _____ Sex: _____

Address: _____ City/State/Zip: _____

Phone: (H): _____ (W): _____ (C): _____

E-mail Address: _____

Occupation: _____

In Case of Emergency Contact: _____

Relationship & Phone: _____

Family Physician: _____ Phone: _____

How did you hear about us? _____

Do you participate in a regular exercise program? Yes / No If so, please describe: _____

Release of Liability

1. In consideration of being allowed to participate in the personal fitness training activities and programs of *The Wellness Solution* and to use its facilities, equipment and services, in addition to the payment of any fee or charge, I do hereby forever waive, release and discharge *The Wellness Solution* and its officers, agents, employees, instructors, representatives, independent contractors and associated entities, executors and all others acting on their behalf from any and all claims or liabilities for injuries or damages to my person and/or property, including those caused by the negligent act or omission of any of those mentioned or others acting on their behalf, arising out of or connected with my participation in any activities, programs, classes or services of *The Wellness Solution* or the use of any equipment at various sites, including home, provided by and/or recommended by *The Wellness Solution* (PLEASE INITIAL: _____)

2. I have been informed of, understand and am aware that strength, flexibility, endurance and balance exercise, including the use of equipment, is a potentially hazardous activity. I also have been informed of, understand and am aware that fitness activities involve a risk of injury, including a remote risk of death or serious disability, and that I am voluntarily participating in these activities and using any equipment with full knowledge, understanding and appreciation of the dangers involved. I hereby agree to expressly assume and accept any and all risks of injury or death. (PLEASE INITIAL: _____)

3. I do hereby further declare myself to be physically sound and suffering from no condition, impairment, disease, infirmity or other illness that would prevent my participation in these activities or use of equipment. I do hereby acknowledge that I have been informed of the need for a physician's approval for my participation in the exercise activities, programs and use of exercise equipment. I also acknowledge that it has been recommended that I have a yearly or more frequent physical examination and consultation with my physician as to physical activity, exercise and use of exercise equipment. I acknowledge that either I have had a physical examination and have been given my physician's permission to participate or I have decided to participate in the exercise activities, programs and use of equipment without the approval of my physician and do hereby assume all responsibility for my participation in said activities, programs and use of any equipment. (PLEASE INITIAL: _____)

4. I understand that *The Wellness Solution* providing and maintaining an exercise/fitness program for me does not constitute an acknowledgment, representation or indication of my physiological well-being or a medical opinion relating thereto. (PLEASE INITIAL: _____)

Date: _____

Signature: _____



MEDICAL HISTORY QUESTIONNAIRE

YES NO

- | | | |
|---|--------------------------|--------------------------|
| 1. Do you take any prescribed medication on a permanent or semi-permanent basis? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Do you have a seizure disorder (epilepsy)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Do you have diabetes; Type I (IDDM) or Type II (NIDM)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you ever been found to be anemic (low blood count)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you have High Blood Pressure (hypertension)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Do you have or have you ever had asthma? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Do you have or have you ever had severe neck injury? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Have you ever been knocked out? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Have you had a broken bone or fracture in the past 2 years? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Have you ever injured your back? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Do you have back pain? If YES, circle the best answer below. | <input type="checkbox"/> | <input type="checkbox"/> |
| <i>Almost Never Seldom Occasionally Frequently with vigorous exercise or heavy lifting</i> | | |
| 12. Have you had knee pain in the past 2 years that has disabled you for longer than a week? | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Do you have other physical conditions, which cause pain? | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Have you had any surgical procedures? | <input type="checkbox"/> | <input type="checkbox"/> |

PLEASE EXPLAIN ALL “YES” ANSWERS BELOW. PLEASE REFERENCE THE QUESTION NUMBER.

Reviewed by Trainer/Instructor Signature: _____