Health Assessment Questionnaire

All information collected will be kept confidential by the Aztec Fitness staff and will not be viewed or shared with Gen-Probe. Please print all information.

This form must be completed prior to participating in the group exercise, bootcamps, massage therapy or personal training programs.

MEMBER INFORMATION

Name:_____________________________ Date: ___________

Phone:_________________ DOB:___________

Address, zip:____

Email:_____________________________

In case of emergency, contact (name & phone): _______________________________

Physician name & phone: ____

EXERCISE HISTORY

Do you exercise regularly?___________ **IF YES**, for how long? ____years _____months

What type of activities/exercises do you participate in? ___________________________

IF NO, how long has it been since you have regularly participated in an exercise program? _____years _____months

What were the reason(s) for discontinuing your exercise program? ___`__________________

ACTIVITY LEVEL: Consider your physical activity patterns during the past three (3) months. Circle the descriptive item below from each of the three categories below that best describes your average activity pattern for the past three months.

INTENSITY	DURATION	FREQUENCY
1. Continuous light effort	1. < 10 minutes	1. < once per month
2. Continuous moderate effort	2. 10-20 minutes	2. 1-4 times per month
3. Continuous moderately heavy effort	3. 20-30 minutes	3. 1-2 times per week
4. Intermittent vigorous effort	4. 30-60 minutes	4. 3-5 times per week
5. Continuous vigorous effort	5. > 60 minutes	5. > 5 times per week

HEALTH & FITNESS GOALS

1. ____

2.____

3____

PRESENT HEALTH CONDITIONS

Please check the appropriate box of the condition(s) below that apply to you:

Irregular hear rate or other arrhythmia
Obesity
Cancer
Stroke
Epilepsy/Seizures
Osteoporosis
Shortness of breath
Fainting/Light-headedness
Ankle Swelling
Kidney disease
Thyroid or other metabolic disorders

Lung or Pulmonary Condition
Asthma
Chronic bronchitis
Arthritis
Anemia
Fatigue (unexplained or unusual)
Other (please specify)______________
____
____
____

MEDICAL DATA – PRIMARY RISK FACTORS

1. Age: ________________ 2. Gender: ☐ Male ☐ Female

Do you currently have any of the following conditions? (check all appropriate boxes)

DIAGNOSED HIGH BLOOD PRESSURE: ≥120/80 mmHg, confirmed by measurements on at least 2 separate occasions, **OR** on Antihypertensive Medication. ☐ YES ☐ NO

DIAGNOSED HIGH CHOLESTEROL: Total Serum Cholesterol > 200 mg/dL **OR** HDL < 40 mg/dL ☐ YES ☐ NO

CURRENT CIGARETTE SMOKER: ☐ YES ☐ NO

FAMILY HISTORY: A heart attack or sudden death in father or other male first-degree relative before 55 years of age, **OR** in mother or other female first-degree relative before 65 years of age. ☐ YES ☐ NO

DIABETES MELLITUS: Insulin Dependent Diabetes Mellitus ☐ YES ☐ NO
OR Non-insulin Dependent Diabetes Mellitus
IF YES, how long have you had Diabetes? years months

SEDENTARY LIFESTYLE/PHYSICAL INACTIVITY: Do you currently sit for a large period of the day **AND** do not participate in regular exercise or active recreational pursuits? ☐ YES ☐ NO

MEDICAL DATA – SECONDARY RISK FACTORS

1. Have you experienced pain/discomfort (tightness) in the chest, neck, jaw, arms, or other areas at rest or with exertion?__________________ **IF YES**, under what circumstances? ______________________

____

2. Do you have any back, joint, tendon, or muscular pain (shoulders, knees, hips, ankles,etc.)?____________________

   IF YES, please explain: ______________________________________

____

3. Have you had any surgeries in the past year that would affect exercise? ____________________**IF YES**, please

   explain: ____

   ____

4. Please list any medications that you are taking:

Name	Reason
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________

5. Have you ever been advised by a physician ***NOT*** to exercise?____________ **IF YES**, please describe:__________

____

6. Do you know of any other reason why you should not participate in regular physical activity?____________

   IF YES, please explain: ______________________________________

7. Additional comments regarding medical or exercise history: ______________________________

____

____

Nutritional Habits

1. How many meals do you have a day? _____
2. Do you have any food allergies? _____ If so, towards which food? ______________________________
3. Do you drink alcohol? _____ If so, how many drinks per week? _____
4. When would you say is your biggest meal of the day? _____
5. Have you ever participated in a nutrition regimen/diet? _____ If so, which one? ________________________

I certify to the best of my knowledge that the above information is true and correct:

Signed:_______________________________________ Date: ______________________

Fitness Staff:____________________________________

THANK YOU FOR TAKING THE TIME TO FILL OUT THIS QUESTIONNAIRE!

Release of Liability Waiver

Because physical exercise can be strenuous and subject to risk of serious injury, we urge you to obtain a physical examination from a doctor before using any exercise equipment or participating in any exercise activity. You agree that by participating in physical exercise, exercise therapy, you do so entirely at your own risk. Additional suggestions for food supplements are entirely your responsibility and you should consult a physician prior to undergoing any dietary or food supplement changes. You agree that you are voluntarily participating in these activities and assume all risks of injury, illness, or death.

You acknowledge that you have carefully read this “waiver and release” and fully understand it is a release of liability. You expressly agree to release and discharge the trainer or therapist from any and all claims or cause of action and you agree to voluntarily give up or waive any right that you may otherwise have to bring a legal action against the trainer or therapist for personal injury or property damage. To the extent that stature or case law does not prohibit releases for negligence, this release is also for negligence.

If any portion of this release from liability shall be deemed by a Court of competent jurisdiction to be invalid, then the remainder of this release from liability shall remain in full force and effect and the offending provision or provisions severed here from.

By signing the release, I acknowledge that I understand its content and that this release cannot be modified orally.

Participant Signature_____________________________Date:_______________

Print Name ____________________________________

Signature of Aztec Fitness staff:____________________Date:_______________

Payment and Cancellation Notice Agreement

I,____________________retain Aztec Fitness to render bootcamp, personal training, strength and conditioning, and exercise services for me. In exchange and consideration for such services, I agree to pay one of the following rates (*please check one*):

Once a week: $80 month (20 per class)

Twice a week: $136 month (17 per class)

3 times a week: $180 month (15 per class)

4-5 times a week you will pay $12 per class ***depending on the number of people wanting this option, I will discuss this with you personally.***

Payment information:

☐ VISA ☐MC ☐ AMEX ☐ DISC ☐ Check/Cash

CC#__________________________________

EXP: ___________

CSC#: _________

If I choose to prepay, an account will be set up in my name with Aztec Fitness. The amount indicated above will be deducted from my account after each appointment and I will receive an itemized invoice notifying me of payment when my account reaches zero.

Each of the indicated appointments shall be 60 minutes in duration.
I understand that there are NO REFUNDS, but I can receive a credit for classes not attended after it is discussed with an Aztec Fitness trainer. Otherwise, I will be charged for any session not attended.

Signature__________________________________ **Date** ___________