CLIENT RECORD

Name:_____

Address:_____

City:_____ St:_____ Zip:_____

Date of Birth:_____ Program Start Date:_____

Phone: (home)_____ (mobile)_____

Email address to contact you: _____

Who is your primary care physician? _____ Facility: _____

Do you have a secondary medical provider? (Ex: physical therapist, orthopedic surgeon, chiropractor) _____

Emergency contact person? _____ Phone: _____

HEALTH HISTORY

Medical Warnings

Yes/No Initials

Have you recently experienced (within the past week) any of the following: numbness, tingling, radiating pain, loss of range of motion, open wounds, night pain, pain above a 4 on a scale of 1 to 10, or swelling? _____ _____ _____

Heart Problems _____ _____ _____

High Blood Pressure _____ _____ _____

What is your blood pressure? _____

Respiratory Problems _____ _____ _____

Diabetes (either type I or II)? _____ _____ _____

What is your Hba1c level? _____

What was your last home-tested sugar level? _____

Do you have any close relatives with any of the medical conditions listed above? _____ _____

If so, which family member(s)? _____

Are you over 45 years old (men) 55 years old (women)? _____ _____ _____

Are you pregnant? _____ _____ _____

When did you last have a complete medical physical exam? _____

Are you on any medication? _____ _____ _____

If yes, name of medication(s) and describe what it is for:

_____

If you answered YES to any of the above questions, you and your trainer should consult Appendix A. We take your health seriously and it may be necessary for you to seek medical approval before participating in this exercise program.

	Yes/No	Initials
Do you have written medical approval to participate in this program?	_____	_____
If NO, do you plan to seek medical approval?	_____	_____

CONTINUED

Yes/No Initials

Have you had any of the following:

Surgery in the last three months? _____
_____ _____ _____

Major illness or hospitalization in the last three months?_____ _____ _____
_____

Major muscle, joint, or back disorder?_____ _____ _____
_____

Any other illness or health problem not listed above?_____ _____ _____
_____

How would you rate your general health? (circle one)

[Excellent] [Good] [Fair] [Poor]

Please complete the following chart if you have ever had an injury which affected your activity level or caused you pain or discomfort.

	INJURY 1	**INJURY 2**	**INJURY 3**
Body part injured			
Date occurred (Mo/Yr)			
Current status (circle)	1. Recovered 2. Getting better 3. Getting worse 4. Unchanged	1. Recovered 2. Getting better 3. Getting worse 4. Unchanged	1. Recovered 2. Getting better 3. Getting worse 4. Unchanged
Severity of problem (circle)	1. Pain after activity 2. Pain during activity 3. Pain all the time	1. Pain after activity 2. Pain during activity 3. Pain all the time	1. Pain after activity 2. Pain during activity 3. Pain all the time
Type of treatment (circle one)	1. Physician 2. Surgeon 3. Chiropractor 4. Physical Therapist	1. Physician 2. Surgeon 3. Chiropractor 4. Physical Therapist	1. Physician 2. Surgeon 3. Chiropractor 4. Physical Therapist

Are you currently in medical treatment for any of the injuries listed above? _____ _____

LIFE STYLE

Yes/No **Initials**

Do you smoke? _____ _____

Do you consume alcohol? _____ _____

If YES, how many drinks per week? (circle one)

Male:	[1 – 7 drinks]	[8 – 14 drinks]	[15+ drinks]
Female:	[1 – 4 drinks]	[5 – 7 drinks]	[8+ drinks]

How many hours of sleep do you get? (circle one)

[7 – 8 hours] [<7 OR >9 hours]

Do you restrict your diet in any way? _____ _____

How many calories do you eat a day? _____

Do any positions, exercises, or activities cause you pain or anxiety? _____ _____

Please describe: _____

Do you perform regular aerobic and strength exercises? _____ _____

What activities? _____

How often per week? (circle one)

[<150 min] [150 min] [180 min] [210 min]

What is your occupation? _____

What are your cholesterol levels? (circle one for each type)

HDL:	[above 60]	[40 – 60]	[below 40]
LDL:	[≤100]	[100+]	
Triglycerides:	[≤150]	[150+]	

APPENDIX A

Staff and Clients: Please Read before beginning exercise program.

Coronary Artery Disease Risk Factor Thresholds: ACSM Risk Stratification

Risk Factors

Family History

CAD or death in family before 55 years of age of father or other male first-degree relative, or before 65 years of age in mother or other first-degree relative

Cigarette smoking

Cigarette smoker or those who quit within the previous 6 months.

Hypertension

Systolic blood pressure of higher or equal 140 mm or diastolic blood pressure of or higher than 90 mm, confirmed by measurements on at least two separate occasions, or on antihypertensive medication.

Dyslipidemia

Low-density lipoprotein (LDL) cholesterol lower than 130 mg or high-density HDL cholesterol lower than 40 or on lipid-lowering medication. If total serum cholesterol is all that is available use greater than 200 rather than low-density lipoprotein (LDL) lower than 130

Impaired fasting glucose

Fasting blood glucose equal or greater than 100 mg confirmed by measurements on two separate occasions.

Obesity

Body Mass index of great or equal to 30 KG or waist girth of greater than 102 cm and 88 cm for women or waist / hip ratio of greater than or equal to .95 for men and .86 for women.

Sedentary lifestyle

Persons not participating in a regular exercise program or meeting the minimal physical activity recommendations from the US Surgeon General's Report.

Fitness Program Agreement

Agreement. I commit to my fitness program and keeping to the guideline set forth by my fitness program. I understand that there are no shortcuts. I understand Medical Exercise Trainers and its staff do not provide quick fixes and easy answers. I will progress within my own ability, but will be required to consistently follow all of the components outlined in the fitness program.

I understand medical exercise/post rehab, and training sessions are not transferable or refundable.

I understand that Medical Exercise Trainers staff do not diagnose or treat.

Cancellations. You may cancel a scheduled appointment 24 hours before that appointment without a charge**. When cancellations are made within less than a 24 hour notice, you will be billed for that session.**

Waiver and Claims. You expressly agree that you undertake all risk at Medical Exercise Trainers including equipment and services, at your sole liability. You further agree that Medical Exercise Trainers, its employees, sub-contractors, agents, or officers are not liable for any damages or injuries to you or your property. You agree that Medical Exercise Trainers, its employees, sub-contractors, agents, and officers are not subject to any claims or demand for injuries or damages whatsoever, including without limitations, those injuries or damages resulting from acts of passive or active negligence on the part of Medical Exercise Trainers, its employees, sub-contractors, agents, or officers. You also agree that Medical Exercise Trainers is not responsible or liable for articles that are damaged, lost or stolen in or about the premises of Medical Exercise Trainers. This agreement constitutes the entire agreement between you and Medical Exercise Trainers. This agreement may only be amended or altered in writing, signed by both parties. This agreement will be interpreted under the laws of the District of Columbia.

You acknowledge that you have read and understand the terms and conditions of this agreement, and that you agree to be bound by such terms and conditions.

Client Name (printed) _____ Date _____

Signature: X_____

Fitness Program
Release of Information

Client's Name:_____
Fitness Professional:_____
Medical Professional:_____
Medical Facility:_____

TO WHOM IT MAY CONCERN:
Please furnish to Medical Exercise Trainers (hereinafter “Facility”) and/or any of its personnel, information, copies of any and all hospital and medical records or reports of any sort, charts, notes, x-rays, lab reports and prescription information, including the right to inspect and copy such records upon request.

Medical Exercise Trainers is to be furnished any and all other information without limitation pertaining to any confinement, examination, treatment or condition of myself, including medical, dental, psychological or other treatment, examinations, or counseling for any condition, medical, dental, and/or psychological upon request.

This AUTHORIZATION shall be considered as continuing and you may rely upon it in all respects unless I have previously advised you in writing to the contrary. It is expressly understood by the undersigned and you are hereby authorized with the same validity as though an original has been presented to you.

Signature:_____ Date:_____

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Medical Exercise Trainers services do not provide diagnosis or medical treatment.

Thank you for choosing Medical Exercise Trainers!