KM FITNESS
Health Coaching - Fitness Training

Name	Start Date	Birthday
Address		
City	State	Zip
Home Phone	Work Phone	Mobile Phone
Email		
How did you hear about us?		
Motivation for Contacting us?		

AGREEMENT RELEASE AND ACKNOWLEDGEMENT OF RISK

Thank you for the opportunity to help you achieve your fitness goals. You are responsible for ensuring that your exercise program is the right one for you. We strongly recommend that you consult with your physician before beginning or modifying your exercise regime. By signing below, you hereby represent, warrant and agree as follows:

1. You are in good health and have notified us of any pre-existing medical conditions that you have.

2. You have consulted with your physician prior to participating in exercise activities at the studio or, if you have not, you accept and assume all of the risks (including potential physical injury) related to participating in exercise activities without consulting your physician.

3. We are not responsible for the loss or damage to any valuables you bring to or store at the studio.

4. You will not use defective equipment and you will report defective equipment to a KM Fitness employee.

5. You hereby agree to indemnify and hold harmless the KM Fitness Studio and and their affiliates, and their respective members, principals, owners, officers, directors, employees, agents, representatives, successors and assigns (the “Indemnified Parties”) from any and all claims, demands, actions, and causes of action, including personal injury, and all other liability whatsoever, arising out of your participation in the KM Fitness training program, the use of equipment located at the KM Fitness studio and any and all violation(s) of codes, statutes, licensing requirements or registrations of the state in which the KM Fitness studio is located, whether known or unknown as of the date hereof.

6. You agree to reimburse any Indemnified Party for any attorney's fees and costs incurred to enforce the provisions of this Agreement, Release and Acknowledgement of Risk.

8. No refunds will be made on prepaid sessions and appointment cancellations must be made by 8:00 pm the previous night.

By signing below, you acknowledge that you have read the foregoing, understand it and agree to the terms.

Signature	Print Name	Date
*If client is under 18, the signature of a parent or guardian is required below		
Signature (Parent or Guardian	Print Name	Date
Parent or Guardian Address		

Medical Screening

☐ Do you have any personal history of heart disease (coronary or atherosclerotic disease)?

☐ Any personal history of diabetes or other metabolic disease (thyroid,renal,liver)?

☐ Any personal history of pulmonary disease, asthma, interstitial lung disease or cystic fibrosis?

☐ Have you experienced pain or discomfort in your chest apparently due to blood flow deficiency?

☐ Any unaccustomed shortness of breath (perhaps during light exercise)?

☐ Have you had any problems with dizziness or fainting?

☐ Do you have difficulty breathing while standing or sudden breathing problems at night?

☐ Have you experienced a rapid throbbing or fluttering of the heart?

☐ Do you suffer from ankle edema (swelling of the ankles)?

☐ Have you experienced severe pain in leg muscles during walking?

☐ Do you have a known heart murmur?

☐ Has your serum cholesterol been measured at greater than 200 mg/dl?

☐ Do you smoke Cigarettes?

☐ Has your HDL (the "good" cholesterol) been measured at greater than 60 mg/dl?

☐ Would you characterise your lifestyle as "sedentary"?

☐ Have you had a high fasting blood glucose level on 2 or more occasions (>=110mg/dl)?

☐ Are you 20% or more overweight or have you been told your “BMI” was greater than 30?

☐ Have you been assessed as hypertensive on at least 2 occasions (systolic > 140 mmHg or diastolic > 90mmHg)?

☐ Do you have any family history of cardiac or pulmonary disease prior to age 55?

Medical History - Detail

☐ Are you currently being treated for high blood pressure? If you know your average BP, please enter: _____/_____

Please check all conditions or diagnoses that apply:

☐ Abnormal EKG?	☐ Limited Range of Motion?	☐ Stroke?
☐ Abnormal Chest X-Ray?	☐ Arthritis?	☐ Do You Suffer from Epilepsy or Seizures?
☐ Rheumatic Fever?	☐ Bursitis?	☐ Chronic Headaches or Migraines?
☐ Low Blood Pressure?	☐ Swollen or Painful Joints?	☐ Persistent Fatigue?

☐ Asthma?
☐ Bronchitis?
☐ Emphysema?
☐ Other Lung Problems?
☐ Foot Problems?
☐ Knee Problems?
☐ Back Problems?
☐ Shoulder Problems?
☐ Recent Broken Bones?
☐ Stomach Problems?
☐ Hernia?
☐ Anemia?
☐ Are You Pregnant?

☐ Has a doctor imposed any activity restrictions? If so, please describe:

_____

_____

_____

Family History

Have your mother, father, or siblings suffered from (please select all that apply):

☐ Heart attack or surgery prior to age 55.
☐ Stroke prior to age 50.
☐ Congenital heart disease or left ventricular hypertrophy.
☐ Hypertension
☐ Leukemia or cancer prior to age 60.
☐ High cholesterol
☐ Diabetes
☐ Obesity
☐ Asthma
☐ Osteoporosis

Medications

Please Select Any Medications You Are Currently Using:

☐ Diuretics	☐ Other Cardiovascular
☐ Beta Blockers	☐ NSAIDS/Anti-inflammatories (Motrin, Advil)
☐ Vasodilators	☐ Cholesterol
☐ Alpha Blockers	☐ Diabetes/Insulin
☐ Calcium Channel Blockers	☐ Other Drugs (record below).

Please list the specific medications that you currently take and any other medical conditions or activity restrictions That You May Have. It is important that this information be as accurate and complete as possible.

_____

_____

_____

☐ Is any of this information critical to understanding your readiness for exercise? Are there any other restrictions on activity that we should know about?

Lifestyle

☐ Are you a cigarette smoker? If so, how many per day? _____

☐ Previously a cigarette smoker? If so, when did you quit? _____

How many years have you smoked or did you smoke before quitting? _____

Do you/did you smoke (Circle one): Cigarettes Cigars Pipe

Please Rate Your Daily Stress Levels (select one):

☐ Low ☐ Moderate ☐ High but I enjoy the challenge ☐ High: sometimes difficult to handle ☐ High: often difficult to handle.

☐ Do you drink alcoholic beverages?

How many units of alcohol do you consume per week: _____

(see Alcohol Units Chart)

Alcohol Units Table

Type of Drink	Units
½ pint of beer	1
1 glass of wine	1
1 pub measure of spirits (Gin, Vodka etc.)	1
1 can of beer	1.5
1 bottle of strong lager	2.5
1 can of strong lager	4
1 bottle of wine	7
1 litre bottle of wine	10
1 bottle of fortified wine (port, sherry etc.)	14
1 bottle of spirits	30

NUTRITION

Breakfast:

Lunch:

Dinner:

Snack:

Which Best Describes you:

☐ I can eat practically anything I want and find it hard to gain weight.

☐ I can lose or gain weight by adjusting my activity level/eating habits

☐ I can gain weight easily and have to watch what I eat

How do you plan for your meals?				
How often do you eat out of habit or not eat at all?	□ Most times	□ Sometimes	□ Rarely	□ Never
Have you participated in any weight management programs in the last 10 years? What has worked/not worked? Why?	□ Yes □ No			

Informed Consent Form

Assessment Objectives. The assessment you are about to undergo is designed to give a reasonable measure of your current level of fitness, and will include the following (Check where appropriate):

[ ] Aerobic Capacity
[ ] Body Composition
[ ] Lung Function
[ ] Flexibility
[ ] Muscular Strength
[ ] Muscular Endurance

Explanation of Procedures. The tests will be explained to you by the member of staff and they will be pleased to answer any questions you may have. Certain pieces of specialized equipment will be used to perform the assessment, and you can stop the test at any point if you feel uncomfortable or unwell.

Potential Risks. Because of the nature of the assessment, a level of exertion is required. This exertion will cause temporary changes which will increase the heart rate and raise the blood pressure. This may place participants with cardiovascular or other disease – whether diagnosed or undiagnosed – at significant risk for adverse events or even death. In addition, as with all vigorous physical activity, there exists a risk musculoskeletal injury. Please note that while these outcomes are rare, it is quite common for participants to experience some stiffness in the muscles in the next few days after testing. Our staff are trained to perform assessments and first aid and will respond quickly to any problems.

Potential Benefits. Your assessment results will help to determine your present level of fitness, and highlight any areas of specific need. This will be particularly useful when designing an exercise program that will be personalized, safe, and effective.

Consent. I have read the information on this page and I understand it. Any questions concerning the information and procedures have been answered to my satisfaction. I also understand that I am free to stop the assessment at any time and seek professional medical advice or opinion.

Any information derived from the assessment is confidential and will not be disclosed without my permission to anyone other than my Doctor or the staff of this facility. However, I agree that information from the assessment not attributable to me may be used for research purposes and stored on an electronic database.

Participant Signature: _____

Witness Signature: _____

Date: _____

Medical Clearance Form

Dear _____,

_____ is interested in taking part in a fitness assessment program that we currently offer. The program involves sub-maximal measurements of cardio-respiratory fitness, body composition, flexibility, and muscular strength and endurance. All assessment protocols will be administered by personnel qualified in assessment techniques and first aid.

The participant has completed a readiness questionnaire which has highlighted the need for medical clearance. By completing this form, you are not assuming any responsibility for our assessment program. If, however, you know of any reason why the participant should not undertake a basic assessment of fitness, we would be most grateful if you could indicate the reason below.

Thank you for your co-operation in this matter.

Patient: _____

_____ I know of no reason why the applicant may not participate

_____ I believe the applicant can participate, but I urge caution because:

_____

_____

_____ The applicant should not engage in the following activities:

_____

_____

_____ I recommend that the applicant NOT participate.

Signature: _____

Address: _____

_____

_____

Telephone: _____

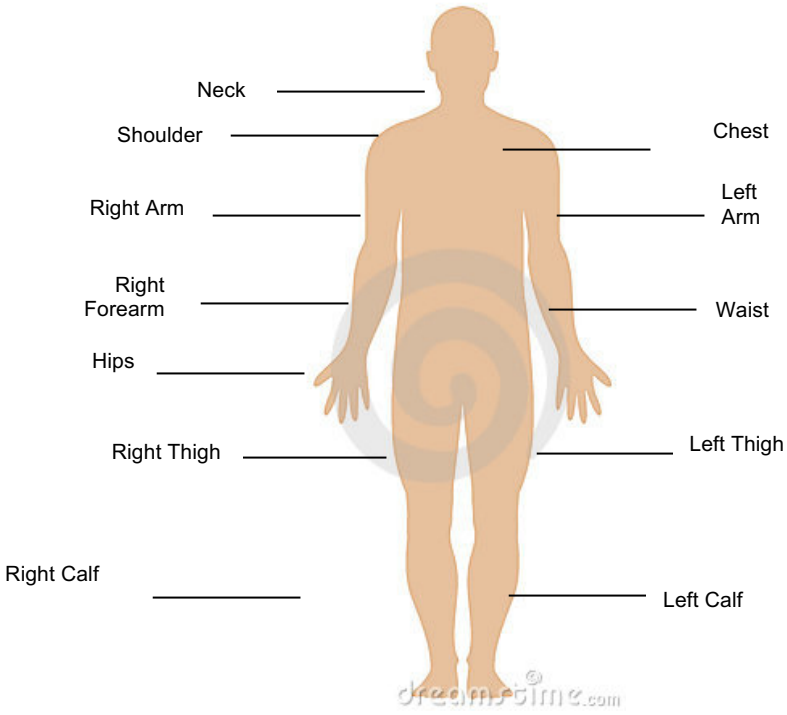
Fitness Assessment				
Starting Pulse	**Resting BP**	**Height**	**Weight**	**Bodyfat Direct Entry** Fat %:_____

Body Fat Test (choose one measurement type)

Jackson Pollock 4-Pinch Fat% Tricep: Abdomen: Iliac: Thigh:

Body Measurements (mark circumferences in either inchese or cm)

Measurement Unit ☐ inches ☐ cm



Notes

Waist-Hip Ratio	Waist:_____	Hips:_____

Strength Testing			**Cardiovascular Test**	
Push Ups Total Pushups:_____	**Sit Ups:** No. of situps in 1 minute: _____	**One Mile Walk:** Time: _____ HR: _____	**3-Minute Step Test** or Ending HR:_____bpm	**Ebbeling Submax Treadmill** Speed:_____ Ending HR: _____

Grip Strength Test (CPAFLA)			**Sit-Reach Hip Flexion**	
Grip Left:_____	Grip Right: _____	Total Grip: _____	Trial 1: _____ Trial 2: _____ Trial 3: _____	Best of 3 trials: _____