

ULTIMATE-U FITNESS CLIENT APPLICATION

Please return all materials to JD Doyle, jd@ultimate-u.com or Fax 888-781-5982

Name _____ E-Mail _____

Date _____ Phone (Home) _____ (Cell) _____

Address _____

Age: _____ Weight _____ Height: _____ Date of Birth: _____

Please state what it is that you hope to achieve from a training program.

Have you ever or do you currently exercise? Please describe what type, how often, how long.

Please describe any past or current injuries, illnesses, or orthopedic problems.

Do you currently work out at a fitness center or at home? Where would you like to train?

Please list the days and times when it would be most convenient for you to train/ meet.

How many hours per week can you commit to exercise? _____

Do you prefer a male or a female trainer? _____

Are you interested in receiving more information on a Diet/ Nutritional Plan? _____

Are you currently taking any medications? If so, please list name and dosage.

Are you currently taking any vitamins or nutritional supplements? If so, please list.

How did you hear about our company or trainer(s)? _____

Physical Activity Readiness Questionnaire (PAR-Q)

Please check the YES or NO column opposite each question as it applies to you.

Yes	No	
		1. Has your doctor ever informed you that you have heart trouble, or recommended you engage in only medically supervised physical activity?
		2. Do you frequently experience pain in your heart or chest or chest pain that occurs during physical activity?
		3. Do you often feel faint or have spells of severe dizziness?
		4. Has a doctor ever informed you that your blood pressure is too high?
		5. Are you aware of, or has a doctor ever informed you of a bone or joint problem such as arthritis that has been aggravated by exercise or might be made worse with exercise?
		6. Is there any good reason, not mentioned here, why you should not follow a vigorous conditioning program without medical supervision even if you wanted to?
		7. Are you over 65 and not accustomed to vigorous exercise?

8. **OTHER MEDICAL HISTORY:** Please discuss any medical conditions that would be important to know related to designing, implementing and evaluating your individualized vigorous conditioning program: (i.e., low back pain, pregnancy, current illness, diabetes, high blood pressure, smoking, cartilage tear, current medications, past injuries, etc.)
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Medical Clearance: If you have answered YES to any of the above questions, or if there are any physical problems that would possibly impair your partaking in an individualized, vigorous conditioning program or put you at any risks, you will need to have a **Medical Clearance Form** completed by your doctor prior to starting your conditioning program.

Waiver of Liability

As a participant in an individualized, vigorous conditioning program pursuant to this questionnaire, I voluntarily intend to and will engage in strenuous athletic and physical fitness activities as a part of my overall conditioning program. I understand that these athletic and physical activities involve certain risks and exposure to personal injury. These risks and exposure I voluntarily assume by engaging:

J.D. Doyle / Ultimate-U Fitness, Inc.

In the capacity of conditioning specialist for the purposes of designing, implementing, and evaluating my conditioning program. In partial consideration for the use of my conditioning program, I hereby release in full and forever discharge, Ultimate-U Fitness, Inc., the American Council on Exercise (ACE), it's fitness instructors, conditioning specialists, directors, officers, agents, and employees, whether acting within the scope of their employment or otherwise, on behalf of myself, my heirs, executors, assigns, administrators, and personal representatives from any and all claims, demands or causes of action relating to deriving from my activities related to my engaging and participating in my conditioning program which may result in my death or in an injury to my person or property of any sort whatsoever.

I declare to the best of my knowledge my answers are true, correct, and complete.

PRINT NAME

Signature

DATE

MD Clearance N/A or YES

Program date _____

Reviewed and Witnessed by:
