

Mike's Mobile Gym

Medical History Questionnaire

Name (Please Print): _____
First MI Last

Address: _____
Street City/State Zip

Phone: _____ / _____ / _____
Home Work Cell

Email: _____ Gender: M F DOB ____/____/____

Employer: _____ Occupation: _____

Emergency Contact: _____
Name Relationship Phone

Primary Care Physician: _____
Name Phone

Specialist: _____
Name Phone

How did you hear about us?

Physician Friend/Relative/Member Newspaper/Radio/Flyer
Event/Fair Website On the Road
Other: _____

Interests: (Please circle all that apply)

Personal Training Athletic Training Nutritional Counseling
Weight Loss Rehabilitation Balance/Core

What do you wish to accomplish from your participation in the fitness program?

(Please circle all that apply)

Increase Strength Improve Posture Increase Energy
Increase Cardiovascular Endurance Improve Flexibility Return to Full Activity
Increase Functional Movement Reduce Pain Lose Weight: _____lbs
(Balance + Core)

Other: _____

Medical History: (Please check all that apply)

I have / have had this condition:

Medications

- Coronary Heart Disease _____
- Congenital Heart Disease _____
- Heart Murmurs _____
- Angina (chest pains) _____
- Irregular Heart Beats _____
- Do you have a pacemaker? _____
- Valve problems _____
- Heart Attack _____
- High Blood Pressure _____
- Stroke _____
- Diabetes (type I / type II) _____
- Epilepsy _____
- Cancer (type) _____
- Stomach Ulcers _____
- Lung Disease (COPD, Asthma, Emphysema, etc) _____
- Arthritis: Type _____ Where _____
- Osteoporosis - Hip Score _____ Spine Score _____
- Surgery within last 12 months: When/What Type _____
- Any chronic illness or condition – What Type _____
- Allergies (Please list) _____
- Do you think you may have an infection? _____
- Hernia (or any condition that may be aggravated by lifting weights) _____
- Do you currently smoke? How many years _____ How frequent _____
- Are you a previous smoker? How many years _____ How frequent _____
- Are you pregnant? _____
- Memory Loss/Alzheimer's/Dementia _____
- Other – Please explain _____
- _____
- _____

General Wellbeing (Please check all that apply)

- I receive strength from my spiritual beliefs
- I have insomnia/trouble sleeping
- I am very concerned for my overall health
- I am stressed

I feel depressed / energy drained

I experience anxiety

What types of exercises do you regularly do? (Please check all that apply)

Walking

Running

Biking

Swimming

Yoga

Tai Chi

Pilates

Elliptical

Weight-lifting

Racquet Sports

Net Sports

Water Sports

Other: _____

Please rate your current activity level: (over the last 6 months)

None (No exercise activity)

Light (Slow walking, limited activity, non-structured)

Moderate (Walk 10 – 20 minutes, 2 – 3 times per week, some structured exercise,
Some weight training)

Heavy (Walk 30 – 60 minutes, 3 – 4 times per week, structured exercise, consistent
Weight training)

Nutrition (Please check all that apply)

I eat out less than 3 times / week

I seldom eat sweets/junk food

I rarely eat snacks between meals

I eat 3-5 fruits + vegetables daily

I eat 3 meals per day

I seldom eat red meats

I seldom eat fried foods or foods high in fat

I drink at least 48 oz of water daily

Possible Orthopedic Limitations to Exercise (Please check all that apply & list type of injury)

Neck _____ Shoulder _____

Back _____ Elbow _____

Hip _____ Wrist _____

Knee _____ Hand _____

Ankle _____ Foot _____

Mike's Mobile Gym

Waiver Form

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I, _____, acknowledge that I have been informed of the recommendation to obtain a Physician's Approval and release prior to beginning an exercise program with MMG (Mike's Mobile Gym) Personal Trainers.

I fully understand that the personal training and exercise program may be strenuous and choose to participate completely voluntarily. I accept all responsibility for my health and any resultant injury or mishap that may affect my well being or health in any way.

I have read and understand this term: _____ (initial)

I understand that I am not obligated to perform nor participate in any activity that I do not wish to do, and that it is my right to refuse such participation at any time during my training sessions. I understand that should I feel lightheaded, faint, dizzy, nauseated, or experience pain or discomfort, I am to stop the activity and inform my Personal Trainer. I give MMG Personal Trainers and the staff of the facilities I train in permission to seek emergency medical services for me should I become injured or ill with the understanding that I am responsible for any expenses incurred.

I have read and understand this term: _____ (initial)

By signing this document, I assume all risk for my health and well-being and hold harmless of any responsibility, the instructor, facility or any persons involved with this program and testing procedures. I understand that questions about exercise procedures and recommendations are encouraged and welcomed.

I have read, understood and completed this questionnaire. Any questions I had were answered to my full satisfaction.

Client Name (Please Print)

Signature

Today's Date

Witness

Mike's Mobile Gym

Informed Consent Form

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I, _____, acknowledge that I have voluntarily chosen to participate in a program of progressive physical exercise by a MMG Personal Trainer. I understand such a program can enhance the musculoskeletal and cardiorespiratory systems. I also understand there are inherent risks in participating in a program of strenuous exercise. I have been informed of the possible strenuous nature of a personal training program and the potential for unusual, but possible, physiological results including, but not limited to, abnormal blood pressure, muscle soreness, fainting, heart attack or death.

I have read and understand this term: _____ (initial)

I certify that the answers to the questions outlined on the Medical History (PAR-Q) form are true and complete to the best of my knowledge. I understand medical clearance may be required based on the answers I gave on the Medical History (PAR-Q) form. I understand and agree that it is my responsibility to inform my Personal Trainer of any conditions or changes in my health, now and on going, which might affect my ability to exercise safely and with minimal risk of injury.

I have read and understand this term: _____ (initial)

I understand that I am not obligated to perform nor participate in any activity that I do not wish to do, and that it is my right to refuse such participation at any time during my training sessions. I understand that should I feel lightheaded, faint, dizzy, nauseated, or experience pain or discomfort, I am to stop the activity and inform my Personal Trainer. I give MMG Personal Trainers and the staff of the facilities I train in permission to seek emergency medical services for me should I become injured or ill with the understanding that I am responsible for any expenses incurred.

I have read and understand this term: _____ (initial)

Cancellation Policies: A Single (1) Hr Session requires a **24** hours notice for cancellation to avoid being charged for (1) session. Core Fit and Xtreme Fit Packages allow (2) emergency cancellations with or without 24 hours notice in its 4 week course and will not be charged for the session. Unfortunately, there are ***NO EXCEPTIONS TO THESE CLAUSES! THESE POLICIES WILL BE STRICTLY ENFORCED.*** The same respect goes to our clients, where your personal trainer must give 24 hours notice for cancellation of a Single (1) Hr Session. If an emergency arrives and the trainer cannot make it to the present destination, the client will be credited for that (1) session or will have the opportunity to reschedule at a mutually convenient time.

Training sessions are one hour in length. The hour will begin when your trainer arrives at the predetermined meeting place (i.e. your house or office). If you are not ready at that time or are interrupted during your training session, your one hour time limit will not be extended. Therefore, it is recommended that you prepare in advance for the arrival of your trainer. Sessions can be performed at your home, home gym, office, or anywhere you need it to be, if allowed. Some geographical restrictions apply to this policy. Determination of an out of range training site is left completely to the discretion of MMG. In the event that you are not at your predetermined meeting place (i.e. your house or office) at your scheduled meeting time, your trainer is required to wait **15** minutes past the scheduled meeting time. If after **15** minutes has passed, and you have not shown for your training session, your trainer is permitted to leave and (1) session will be charged. I understand that MMG Personal Trainers recommend that all sessions be attended to ensure health/fitness progress and consistency.

I have read and understand this term: _____ (initial)

By signing this document, I assume all risk for my health and well-being and hold harmless of any responsibility, the instructor, facility or any persons involved with this program and testing procedures. I understand that questions about exercise procedures and recommendations are encouraged and welcomed.

I have read, understood and completed this questionnaire. Any questions I had were answered to my full satisfaction.

Client Name (Please Print)

Signature

Today's Date

Witness

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Physician's Referral Form

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I hereby give my physician permission to release any pertinent medical information from any medical records to the staff at MMG. All information will be kept confidential. This form will be completed at no cost to MMG or MMG Personal Trainers.

| | |
|---------------------------------|-----------------------|
| | |
| PARTICIPANT Name (Please Print) | Personal Trainer Name |
| | |
| PARTICIPANT Signature | Personal Trainer # |
| | |
| PARTICIPANT Phone # | Today's Date |

YES - The above PARTICIPANT has been examined by me and has my approval to participate in a progressive exercise program. I understand the physical and physiological stressors of the program and see no reason why the above named person should not participate. Any special recommendations and/or contraindications are listed below.

| | | |
|---|--|-----------------|
| | | |
| Physician Name (Please Print) | Physician Address (Street) | |
| | | |
| Physician Signature (M.D.) | Physician Address (City / State / Zip) | |
| | | |
| | | |
| Today's Date | Physician Voice Number | Physician Fax # |
| Activity | Intensity Allowed | |
| Cardiovascular | _____ | |
| Resistance Training | _____ | |
| Flexibility | _____ | |
| Other | _____ | |
| Physician's Recommendations/Contraindications: _____ | | |
| _____ | | |

IMPORTANT! If you do not believe the participant should engage in a progressive exercise program, please check the NO box below.

NO – The above PARTICIPANT has been examined by me and DOES NOT have my approval to participate in a progressive exercise program.