Personalized Conditioning by Grey

Body Made Better by Grey….A Tradition of Caring Since 1984

101 Phoenix Ave, Suite 2D
Enfield, CT 06082
(p) (860) 741-2541

Patient Information			
First Name:	Last Name:	MI:	Date:
Address:			
City:	State:	Zip:	
Email:			
Birth Date: / /	Age:	☐ Female ☐ Male	
Home #: ( ) -	Work #: ( ) - x	Cell #: ( ) -	
Please check 1st choice for phone contact: ☐ Home ☐ Work ☐ Cell		Can we leave a voice mail? (check one) ☐ Yes ☐ No	
How did you hear about us:			

Care Provider Information	
Primary Care Physician:	Secondary Care Physician:

Emergency Contact Information		
Name:	Relationship:	Phone: ( ) -

Emergency Contact Information		
Name:	Relationship:	Phone: ( ) -

Goals:

List any and all goals you have for your exercise program. Examples include weight loss, toning, training for a specific event, fitting into a specific size clothing, etc…. Basically, we want to know why you are coming here. Be as general or as specific as you would like.

1. _____
2. _____
3. _____
4. _____
5. _____

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101 Phoenix Avenue, Suite 2D, Enfield, CT 06082 phone 860.741.541 fax 860.745.5264

Consent for Exercise Program

Exercise Objectives: The purpose of an exercise program is to develop and maintain cardio-respiratory (aerobic) fitness, muscular strength and endurance, body composition, and flexibility. These recommendations follow industry standards and should be conducted under the supervision of a trainer with a minimum of a national certification.

Procedures: A structured exercise program, based on individual needs (obtained fitness assessment information), interests, and/or physician's recommendations will be given to each participant. Exercises may include aerobic activities (treadmill walking/running, cycling, rowing machine exercise, group aerobic activity, swimming, and other such activities), calisthenics and weight lifting to improve muscular strength and endurance, and flexibility exercise to improve joint range of motion. All aerobic programs involve a warm-up, exercise at target heart rate, and cool-down components and follow The American College of Sport Medicine's recommendations.

Potential Risks: All exercise programs/testing are designed to gradually increase workload on the cardio-respiratory and musculoskeletal systems in order to effect improvements. The body's reaction to gradually increasing exercise activities cannot be predicted with complete accuracy. Unusual changes during or following an exercise session may occur. These may include muscular or joint injury, abnormal blood pressure, fainting, disorders of heat beat, and/or very rare instances of heart attack or death.

Potential Benefits: Benefits obtained from a structured and regularly employed exercise program might include a more efficient cardio-respiratory system, an improved musculoskeletal system, a decrease in body fat, a decrease in blood fats, an improvement in psychological function, and a decrease in the risk of heart and other diseases.

Supervision: Your trainer is not responsible for injuries and/or damages that occur when the facility/individual(s) are not supervised by your trainer or during non-operational hours.

Confidentiality: All participant exercise program information will be treated as privileged and confidential and will not be revealed to any person (other than your trainer involved in the participant's exercise program) without expressed written consent. Obtained information, however, may be used for statistical or scientific purposes with right to privacy retained.

Inquiry and Freedom of Consent: I have read the foregoing and I understand the objectives, procedures, potential risks and benefits, supervision issues, and confidentiality involved. Unless otherwise indicated under the "comments" section below, I certify that I am in good health and have no condition that would limit/prohibit my participation in a structured exercise program. I understand that if there are any questions about the procedures or methods used during an exercise session, I should ask my trainer. I realize that injury may result from improper exercise techniques or misuse of exercise facilities or equipment. I agree to be attentive to all instructions given to me and to exercise and use facilities and equipment correctly. I assume responsibility for monitoring my own condition throughout the exercise program and should any unusual symptom(s) occur, I will cease my participation and inform my trainer. I shall also notify my trainer of any changes in my medical status. I consent to the administration of any immediate resuscitation measures deemed advisable by my trainer or other qualified personnel.

Questions/Comments:

_____

_____

I have read and understand the above information and voluntarily consent to participate in a structured exercise program. I realize that I am free to terminate the exercise program at any time. I also understand that physician consent may be required to participate in the program. If it is required and I fail to obtain physician consent, I accept full responsibility for my medical status.

Printed Name: _____

Signature: _____ Date _____

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Health History Questionnaire

Name: _____ Ht: _____ Wt: _____

Gender: Male Female Age: _____ Birth date: ____/____/_____

1. Have you ever had a definite or suspected stroke or heart attack?	Yes	No
2. Have you ever had coronary bypass surgery or any other type of heart surgery?	Yes	No
3. Do you have any other cardiovascular or pulmonary (lung) disease? (**other than** asthma, allergies, or mitral valve prolapsed)	Yes	No
4. Do you have a history of diabetes, thyroid, kidney, liver disease? (circle all that apply)	Yes	No
5. Have you ever been told by a health professional that you have had an abnormal resting or exercise (treadmill) electrocardiogram (EKG)?	Yes	No
6. If you answered YES to any of questions 1-5 please elaborate:		
7. Do you currently have any of the following:		
a. Pain or discomfort in the chest or surrounding areas that occurs when you engage in physical activity	Yes	No
b. Shortness of breath	Yes	No
c. Unexplained dizziness or fainting	Yes	No
d. Difficulty breathing at night except in upright position	Yes	No
e. Swelling of the ankles (recurrent and unrelated to injury)	Yes	No
f. Heart palpitations (irregularity or racing of the heart on >1 occasion)	Yes	No
g. Pain in the legs that causes you to stop walking (claudication)	Yes	No
h. Known heart murmur	Yes	No
Have you discussed any of the above with your personal physician?	Yes	No
8. Are you pregnant or is it likely that you could be pregnant at this time? If yes, what is your expected due date?	Yes	No
9. Have you had surgery or been diagnosed with any disease in the past 3 months? If yes, please list date _____ and surgery/disease_____	Yes	No
10. Have you had high blood cholesterol or abnormal lipids within the past 12 months or are you taking medication to control your lipids?	Yes	No
11. Do you currently smoke cigarettes or have quit within the past 6 months?	Yes	No
12. Have your father or brother(s) had heart disease prior to age 55 OR mother or sister(s) had heart disease prior to age 65?	Yes	No

13. Within the past 12 months, has a health professional told you that you have high blood pressure (systolic ≥ 140 OR diastolic ≥90)?	Yes	No
14. Currently, do you have high blood pressure or within the past 12 months, have you taken any medicines to control your blood pressure?	Yes	No
15. Have you ever been told by a health professional that you have a fasting blood glucose ≥110mg/dl?	Yes	No
16. If you have answered YES to any questions 7-15 please elaborate:		
17. Describe your regular physical activity or exercise program Type: _____ Frequency: ____ days per week Duration: _____ minutes Intensity: low moderate high		
18. Are you currently under any treatments for blood clots?	Yes	No
19. Do you have problems with bones, joints, or muscles that may be aggravated with exercise?	Yes	No
20. Do you have any back/neck problems?	Yes	No
21. Have you been told by a health professional that you should not exercise?	Yes	No
22. Are you currently being treated for any medical condition by a physician?	Yes	No
23. Are there any other conditions (mitral valve prolapsed, epilepsy, history of rheumatic fever, asthma, cancer, anemia, hepatitis, etc.) that may ***hinder*** your ability to exercise?	Yes	No
24. During the past 6 months have you experienced any ***unexplained*** weight loss or gain (>10 lbs for no known reason)?	Yes	No
25. If you have answered YES to any questions 18-24, please elaborate:		

Please list any allergies:

_____

_____

_____

I have answered the Health History Questionnaire accurately and completely. I understand that my medical history is a very important factor in the development of my fitness/wellness program. I understand that certain medical or physical conditions which are known to me, but that I do not disclose to my trainer, may result in serious injury to me. If any of the above conditions change, I will immediately inform my trainer of those changes. I, knowingly and willingly, assume all risks of injury resulting from my failure to disclose accurate, complete, and updated information in accordance with the attached questionnaire. I also understand that in order to properly risk stratify my Health History Questionnaire; my trainer should have a minimum of a national certification as a personal trainer.

_____

Client Name (please print)

_____ _____

Client Signature Date

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Name: _____ Date: _____

Present Medications: (Please include all prescriptions, vitamins, supplements)

Medication Name	For/Purpose	Dosage	Frequency

Are there any medications that have been prescribed to you in the past 12 months which you are not currently taking? If so please list.

_____

_____