



Full Name: \_\_\_\_\_

Address: \_\_\_\_\_

E-Mail \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Preferred contact method \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_

Phone # \_\_\_\_\_

Check class descriptions:

Time/Class

Fitness Bootcamp

Other: \_\_\_\_\_

6 a.m.-7 a.m.

9:15 a.m.-10:15 a.m.

Punchcard

2x/week Circle preferred days: M W F

3x/week

Check if you want to schedule: *Additional fee*

Pre/Post Body Composition Assessment

Name: \_\_\_\_\_

Date: \_\_\_\_\_



## Medical History

1. Are you pregnant? (women only) No  Yes

2. Are you allergic to any medication (aspirin, penicillin, sulfa, etc.)?

No  Yes

If yes, list medications: \_\_\_\_\_

3. Do you take any prescribed medication (aspirin, penicillin, sulfa, etc.)?

No  Yes

If yes, list medications: \_\_\_\_\_

4. Do you have a seizure disorder (epilepsy)? No  Yes

5. Do you have diabetes (adult or juvenile)? No  Yes

If yes, list type and

medications: \_\_\_\_\_

6. Have you ever been found to be anemic (low blood count)? No  Yes

7. Do you have High Blood Pressure (Hypertension)? No  Yes

If yes, list medications: \_\_\_\_\_

8. Do you have or have you ever had the following diseases?

Heart Disease? No  Yes

Lung Disease? No  Yes

Kidney Disease? No  Yes

Liver Disease? No  Yes

9. Do you have asthma? No  Yes

If yes, list medications: \_\_\_\_\_

10. Have you had a broken bone or fracture in the past 2 years? No  Yes

If yes, describe: \_\_\_\_\_

11. Have you ever suffered from a back injury? No  Yes

If yes, describe: \_\_\_\_\_

12. Do you continue to suffer from back pain? No  Yes

If yes, how often: \_\_\_\_\_

13. Have you had knee pain in the past 2 years that has disabled you for longer than a week?

No  Yes

If yes, describe: \_\_\_\_\_

14. Do you have other physical conditions which cause pain (shoulder, inflammation etc.)?

No  Yes

If yes, please describe: \_\_\_\_\_

### **Fitness Goals:**

What are your goals for the next three months?

Have you had your body fat tested?

If yes, what percentage:

Method of testing (calipers, hydrostatic, DEXA, etc.):

Describe your current training routine

Do you have specific fitness goals?

If yes, please describe:

Are you training for a specific event?

If so, which one:

On a scale of 1 to 10, rate your current fitness level (10 being the highest fitness level):

**PLEASE NOTE:** It is wise to seek your doctor's advice before beginning any health/fitness/nutrition program!

Please read and initial the following:

I have read and understand the refund policy.

I have read and understand the make-up day/sick day policy.

I understand that we will workout in the rain. In case of thunderstorm or downpour, class will be rescheduled.

I will do my best to come to every class on time ready to workout.

I will encourage fellow participants, be positive, and give my instructor the attention required to receive necessary instruction.

### **Acknowledgement and Assumption of Potential Risk**

I understand and acknowledge: (a) that these activities, by their very nature, pose the potential risk of serious injury/illness to individuals who participate, (b) that in order to participate in these activities, I agree to assume liability and responsibility for any and all potential risks which may be associated with participation in such activities, (c) Core In Action Bootcamp or Nancy Murray, Danielle Lein, or Jeff Tolle, shall not be liable for any injury/illness suffered by me which is incident to and/or associated with preparing for and/or participating in the activity(ies), (d) that photos and/or videos of me participating in these activities may be taken for the sole purpose of assisting in the instruction and/or for the promotion of future programs. I have no known medical condition which may pose a risk to the health and safety of me or others by participating in the activity (ies).

Participants Signature \_\_\_\_\_ Date \_\_\_\_\_