PERSONAL INFORMATION QUESTIONNAIRE

Client Name (First, MI, Last): ______________________________

Home Address: Street – ______________________________

City - ____________________ State - __________ Zip Code - __________

Home Phone: ______________ **Cell Phone:** ______________ **Work Phone:** ______________

Email Address: ______________________ **Occupation:** ______________

School: ______________________________

Emergency Contact: ______________________ **Phone:** ______________

Financially responsible party if different from above

Name: ______________________ **Relationship:** ______________

Home Address: Street – ______________________________

City - ____________________ State - __________ Zip Code - __________

Home Phone: ______________ **Cell Phone:** ______________ **E-mail:** ______________

- How did you hear about Fitlife?

  ____

What goals do you want to see in the following areas of your life, and when do you want these changes to occur?

- ✓ Physical Activity: ______________ By what date: __________
- ✓ Strength/Endurance: ______________ By what date: __________
- ✓ Body Composition: ______________ By what date: __________
- ✓ Nutritional habits: ______________ By what date: __________

Do you currently participate in any form of physical activity? Yes ☐ / No ☐
If yes, please list these activities.

1. ______________________________
2. ______________________________

By entering my name and initials below, I acknowledge that the information given above is an accurate account of my medical history and is intended for the sole use of developing a safe and effective fitness program by FITLIFE Health Systems, Inc.

Client Digital Signature: ______________________ Initials: __________

Date: ______________

MEDICAL HISTORY

Name (First, MI, Last) ____

Date of Birth ______________________ Age ___________

1) Please check any of the following acute or chronic conditions that apply to you.

Low back pain	Y☐	N☐	Low blood sugar	Y☐	N☐	Wheezing/ coughing	Y☐	N☐
Mid back pain	Y☐	N☐	Diabetes mellitus	Y☐	N☐	Cold hands or feet	Y☐	N☐
Upper back pain	Y☐	N☐	High Cholesterol	Y☐	N☐	Swollen ankles	Y☐	N☐
Stiff Neck	Y☐	N☐	High blood pressure	Y☐	N☐	Skin Problems	Y☐	N☐
Neck pain	Y☐	N☐	Stroke	Y☐	N☐	Stomach Problems	Y☐	N☐
Jaw pain	Y☐	N☐	Lung Disease	Y☐	N☐	Nausea	Y☐	N☐
Insomnia	Y☐	N☐	Asthma	Y☐	N☐	HIV/AIDS	Y☐	N☐
Faint/ Dizziness	Y☐	N☐	Liver Disease	Y☐	N☐	Cancer	Y☐	N☐
Headaches	Y☐	N☐	Kidney Disease	Y☐	N☐	Orthopedic problems	Y☐	N☐
Arthritis	Y☐	N☐	Heart Disease	Y☐	N☐	Muscle cramping	Y☐	N☐
Bursitis	Y☐	N☐	Chest Pain	Y☐	N☐	Numbness/ tingling	Y☐	N☐
Tendonitis	Y☐	N☐	Allergies	Y☐	N☐	Stress	Y☐	N☐

2) Please list your primary care physician ____

Are you currently under the care of the above or any other physician or health care professional? Y☐ N☐

If YES: For what reason(s)

1. ____

2. ____

Physician Name ______________________________ Phone ____________________

Address ____

3) Please list major surgeries and dates:

1. ____

2. ____

4) Are you currently taking any medications?

Prescription Y☐ N☐ List: ____

Non- Prescriptive Y☐ N☐ List: ____

5) Do you smoke? Y☐ N☐ How many packs per week? ____________________

6) Do you use alcohol? Y☐ N☐ How many drinks per week? ____________________

7) I exercise ______ a week for ______ minutes. I stretch ______ times daily☐/ weekly☐.

8) I drink ______ glasses of water a day.

9) Are you participating in a supervised diet program? Y☐ N☐

10) Would you be willing to do a dietary analysis? Y☐ N☐

By entering my name and initials below, I acknowledge that the information given above is an accurate account of my medical history and is intended for the sole use of developing a safe and effective fitness program by FITLIFE Health Systems, Inc.

Client Digital Signature: ______________________________ Initials: __________ Date: ______________

Parent Digital Signature: ______________________________ Initials: __________ Date: ______________

(*if a minor*)

MEMBER AGREEMENT

In order to achieve excellent results in a cost-effective manner each client will have an appointment. The staff can schedule one for you or you can use the FITLIFE website http://www.azfitlife.com. Clients should wear proper workout attire, recognize the diversity in clientele, and demonstrate courtesy and politeness with all personnel/guests at all times.

Appointment times

- Monday/Wednesday from 7 am to 6 pm. (Closing at 7 pm)
- Tuesday/Thursday from 5:30 am to 6pm. (Closing at 7 pm)
- Friday from 7 am to 5 pm. (Closing at 6 pm)
- Saturday from 8 am - 11 am. (Closing at 12 pm)
- Sunday - Closed

_____ (*Initial*) It is my responsibility to schedule every appointment.
_____ (*Initial*) I understand the hours of the facility and agree to be on time.
_____ (*Initial*) If arriving late to an appointment I agree that I have 1 hour from my scheduled appointment time, at the discretion of FITLIFE staff, to complete my session.

Payment

_____ (*Initial*) I understand and agree that all programs at FITLIFE are pre-paid in full.
_____ (*Initial*) I have received, read and understand the fees for service and have chosen _____ session(s) per week at a rate of _____ per month, and will be paid to FITLIFE by the 5th of each month by check, cash or my credit card on file will be charged.
_____ (*Initial*) I understand and agree that any missed appointments can ONLY be made up the following month once the agreed monthly payment is received.

Commitment

My program may include a nutrition plan, cardiovascular schedule, and/or flexibility routine prescribed by a FITLIFE personnel. <u>All visits are non-transferable or refundable.</u>

By typing my name and initials below I signify that I have read and understand all aspects of this Member Agreement and do recognize my legal responsibilities in regard to this contract.

Client Digital Signature: ____ Initials: ___________

Date: _____________________

Parent Digital Signature: ____ Initials: ___________
(*if a minor*)

Date: _____________________

WAIVER AND RELEASE, ASSUMPTION OF RISK AND PARENTAL CONSENT AND INDEMNITY AGREEMENT

In consideration of my minor child being permitted to participate in any way in the **FitLife Health Systems** in sponsored Activities ("Activity"), I agree:

1. I understand the nature of **FitLife Health Systems** activities and the Minor's Experience and capabilities and believe the Minor to be qualified to participate in such Activity. I further acknowledge that I and the Minor are aware the activity will be conducted in facilities open to the public during the Activity. I further agree and warrant and will instruct the Minor that if at any time the Minor believes conditions to be unsafe, he/she will immediately discontinue further participation in the Activity.

2. I FULLY UNDERSTAND that: (a) **FitLife Health Systems** Activities involve risks and dangers of **SERIOUS BODILY INJURY, INCLUDING PERMANENT DISABILITY, PARALYSIS AND DEATH** ("Risks"); (b) these Risks and dangers may be caused by the Minor's own actions, or inaction's, the actions or inaction's of others participating in the Activity, the condition in which the Activity takes place, or THE NEGLIGENCE OF THE "RELEASEES" NAMED BELOW; (c) there may be other risks and social and economic losses either not known to me or not readily foreseeable at this time; and **I FULLY ACCEPT AND ASSUME ALL SUCH RISKS AND ALL RESPONSIBILITY FOR LOSSES, COSTS, AND DAMAGES** incurred as a result of the Minor's Participation in the Activity.

3. **I HEREBY RELEASE, DISCHARGE, COVENANT NOT TO SUE, AND AGREE TO INDEMNIFY AND SAVE AND HOLD HARMLESS FitLife Health Systems,** their respective administrators, directors, agents, officers, volunteers, and employees, other participants, any sponsors, advertisers, and if applicable, owners and lessors of premises on which the Activity takes place (each considered one of the "Releasees" herein) from all liability, claims, demands, losses, or damages on the minor's account caused or alleged to be caused in whole or in part by the negligence of the "Releasees" or otherwise, including negligent rescue operations and further agree that if, despite this release, I, the minor, or anyone on the Minor's behalf makes a claim against any of the Releasees named above, **I WILL INDEMNIFY, SAVE AND HOLD HARMLESS EACH OF THE RELEASEES FROM ANY LITIGATION EXPENSES, ATTORNEY FEES, LOSS LIABILITY, DAMAGE OR COST ANY MAY INCUR AS THE RESULT OF ANY SUCH CLAIM.**

BY TYPING MY NAME AND INITIALS BELOW I SIGNIFY THAT I HAVE READ THIS AGREEMENT, FULLY UNDERSTAND IT'S TERMS, UNDERSTAND THAT I AND THE MINOR HAVE GIVEN UP SUBSTANTIAL RIGHTS BY SIGNING IT AND HAVE SIGNED IT FREELY AND WITHOUT ANY INDUCEMENT OR ASSURANCE OF ANY NATURE AND INTEND IT TO BE A COMPLETE AND UNCONDITIONAL RELEASE OF ALL LIABILITY TO THE GREATEST EXTENT ALLOWED BY LAW AND AGREE THAT IF ANY PORTION OF THIS AGREEMENT IS HELD TO BE INVALID THAT THE BALANCE, NOTWITHSTANDING, SHALL CONTINUE IN FULL FORCE AND EFFECT.

Name of Minor Child: ____

Parent Digital Signature: ______________________________________ Initials: ___________
(*if a minor*)

Date: ____________________

CONSENT TO PUBLISH OR PHOTOGRAPH

Name: ____

I consent to the use by FITLIFE Health Systems of:

1. My name in connection with any publication (including but not limited to Twitter, Instagram, Facebook, newspapers, television, radio broadcasts, books, brochures, magazines, motion pictures, and/or the internet) in such manner and at such times and in such places as FitLife Health Systems without restriction at its sole discretion, shall determine.

2. The taking and reproduction of pictures and slides of the above-named person in connection to FitLife Health Systems related function.

3. Photographs and slides in any publication (including but not limited to newspapers, television and/or radio broadcasts, books, brochures, magazines, motion pictures, and in Internet) in such manner and at such times and in such places as FitLife Health Systems without restriction at its sole discretion, shall determine.

By typing my name and initials below I consent to the above conditions and signify my consent constitutes an irrevocable release.

Client Digital Signature: ____ Initials: ___________

Date: _____________________

Parent Digital Signature: ____ Initials: ___________
(*if a minor*)

Date: _____________________