Name:_____ Date:_____

Instructions:
This is your comprehensive client information sheet. With this sheet, we will ask you to provide relevant personal information. The answers to these questions are essential in order to allow us to design an optimized individual fitness program for you. **Please answer all questions** in the most accurate manner possible while being as concise as possible.

Disclaimer:
Please recognize the fact that it is **your responsibility** to work directly with your physician before, during, and after seeking fitness consultation. As such, any information provided is not to be followed without the prior approval of your physician. If you choose to use this information without the prior consent of your physician, you are agreeing to accept full responsibility for your decision.

Basic Information:

Gender _____ **Age** _____

Height _____ **Weight** _____

Fitness goal _____

Timeline for achieving your goal _____

1) Are you currently exercising regularly (at least 3x per week)? Circle one
Yes No

2) If Yes, briefly describe your workouts and how long you have been consistently doing a workout regimen (examples: time and speed on treadmill, types of resistance training sets and reps)

_____

_____

Lifestyle Information:

3) What do you do for a living?

_____

4) What is your activity level each day? Circle one
None Moderate HIgh

5) Does your job entail shift work? Yes No

6) When do you work? Days Afternoons Nights

7) Please list the physical activities that you participate in outside the gym and outside of work.

_____

_____

8) If you have any diagnosed health problems, list the condition(s)

_____

_____

9) If you are on any medications, please list them.

_____

_____

10) What additional therapies or interventions are being undertaken for the given health problem(s)

_____

_____

11) If you have any injuries, please list them.

_____

_____

12) What additional therapies or interventions are being undertaken for the given injury(s)?

_____

_____

13) What hours each day do you have available to workout?

_____

_____

14) How many meals do you eat outside of cooking at your house?

_____

15) List any food allergies

_____

_____

16) Are there any other foods to which you're particularly sensitive (i.e., which cause excessive gas, bloating, stuffiness, or congestion)?

_____

_____

17) If you're currently using any nutritional supplements, please list them (as well as the doses you're taking) below.

_____

_____

18) If there is any other information you think is relevant to your program design, please share it with us below.

_____

_____

19) Please share your most frequent health, nutrition, or physique complaints and/ or dissatisfactions with us.

_____

_____

You have now completed our client information sheet. Please bring this, along with your current workout schedule (if applicable,) to your first appointment.

T-BOD FITNESS > Informed Consent

Please Fill Out All Information Below

I, (print name) _____ , give my consent to participate in the physical fitness evaluation program conducted by T-BOD FITNESS

Benefits

Participation in a regular program of physical activity has been shown to produce positive changes in a number of organ systems. These changes include increased work capacity, improved cardiovascular efficiency, and increased muscular strength,flexibility, power, and endurance.

Risks

I recognize that exercise carries some risk to the musculoskeletal system (sprains, strains) and the cardiorespiratory system (dizziness, discomfort in breathing, heart attack). I hereby certify that I know of no medical problem that would increase my risk of illness and injury as a result of participation in a regular exercise program.

Testing and Evaluation Results

I understand that I will undergo initial testing to determine my current physical fitness status. I also understand that such screening is intended to provide T-BOD FITNESS with essential information used in the development of individual fitness programs. I understand that my individual results will be made available only to me. I also understand that the testing is not intended to replace any other medical test or the services of my physician. I will be provided a copy of all results. I may share the results with whomever I please, including my personal physician. By signing this consent form, I understand that I am personally responsible for my actions during my tenure at T-BOD FITNESS, and that I waive the responsibility of T-BOD FITNESS if I should incur any injury as a result of my negligence.

Name:_____

Signature: _____ Date: _____

Signature of Parent: _____ Date: _____
Or Guardian (for participants under the age of majority)

T-BOD FITNESS > Confidentiality Agreement
Please Fill Out All Information Below

I, (print name) _____ understand that the information collected by T-BOD FITNESS will be used for fitness evaluation purposes and for the design, implementation, progression, and maintenance of an individualized fitness program only. I further understand that all such information is confidential and will not be shared with anyone without my prior written authorization, except in the case of a medical emergency or to the minimum extent necessary to achieve a safe and effective fitness program.

Name:_____

Signature: _____ Date: _____

Signature of Parent: _____ Date: _____
Or Guardian (for participants under the age of majority)

T-BOD FITNESS

Physical Activity Readiness Questionnaire

The health benefits of regular physical activity are clear; more people should engage in physical activity every day of the week. Participating in physical activity is very safe for MOST people. This questionnaire will tell you whether it is necessary for you to seek further advice from your doctor OR a qualified exercise professional before becoming more physically active.

GENERAL HEALTH QUESTIONS

Please read the 7 questions below carefully and answer each one honestly:		
Check YES or NO	**YES**	**NO**
1) Has your doctor ever said that you have a heart condition |__| OR high blood pressure |__| ?	|__|	|__|
2) Do you feel pain in your chest at rest, during your daily activities of living, OR when you do physical activity?	|__|	|__|
3) Do you lose balance because of dizziness OR have you lost consciousness in the last 12 months? (Please answer NO if your dizziness was associated with over-breathing, including during vigorous exercise).	|__|	|__|
4) Have you ever been diagnosed with another chronic medical condition (other than heart disease or high blood pressure)? PLEASE LIST CONDITION(S) HERE: _____	|__|	|__|
5) Are you currently taking prescribed medications for a chronic medical condition? PLEASE LIST CONDITION(S) AND MEDICATIONS HERE: _____	|__|	|__|
6) Do you currently have (or have had within the last 12 months) a bone, joint, or soft tissue (muscle, ligament, or tendon) problem that could be made worse by becoming more physically active? Please answer NO if you had a problem in the past, but it does not limit your current ability to be physically active. PLEASE LIST CONDITION(S) HERE: _____ _____	|__|	|__|
7) Has your doctor ever said that you should only do medically supervised physical activity?	|__|	|__|

If you answered NO to all of the questions above, you are cleared for physical Activity. Skip to the PARTICIPANT DECLARATION below and sign where indicated. You do not need to complete the follow-up questions.

Start becoming much more physically active

Start slowly and build up gradually.
You may take part in a health and fitness appraisal.
If you are over the age of 45 yr and NOT accustomed to regular vigorous to maximal effort exercise, consult a qualified exercise professional before engaging in this intensity of exercise.
If you have any further questions, contact a qualified exercise professional.

Delay becoming more active if:

You have a temporary illness such as a cold or fever; it is best to wait until you feel better.
You are pregnant - talk to your health care practitioner, your physician, a qualified exercise professional, and/or complete the ePARmed-X+ at www.eparmedx.com before becoming more physically active.
Your health changes - answer the questions on Pages 2 and 3 of this document and/or talk to your doctor or a qualified exercise professional before continuing with any physical activity program

If you answered YES to one or more of the questions above, complete the Follow-up questions below.

T-BOD FITNESS

FOLLOW-UP QUESTIONS ABOUT YOUR MEDICAL CONDITION(S)

1. **Do you have Arthritis, Osteoporosis, or Back Problems?**
   If the above condition(s) is/are present answer questions 1a-1c. If NO, go to question 2.

1a. Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? YES NO
(Answer NO if you are not currently taking medications or other treatments)

1b. Do you have joint problems causing pain, a recent fracture or fracture caused by osteoporosis or cancer, displaced vertebra (e.g. spondylolisthesis), and or spondylolysis/pars defect (a crack in the bony ring on the back of the spinal column)?

1c. Have you had steroid injections or taken steroid tablets regularly for more than 3 months?

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2. **Do you currently have Cancer of any kind?**
   If the above condition(s) is/are present, answer questions 2a-2b. If NO, go to question 3.

2a. Does your cancer diagnosis include any of the following types: lung/ bronchogenic, multiple myeloma (cancer of plasma-cells), head, and/or neck? YES NO

2b. Are you currently receiving cancer therapy (such as chemotherapy or radiotherapy)? YES NO

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3. **Do you have a Heart or Cardiovascular Condition?** *This includes Coronary Artery Disease, Heart Failure, Diagnosed Abnormality of Heart Rhythm.* If the above condition(s) is/are present, answer questions 3a-3d. If NO, go to question 4

3a. Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? YES NO
(Answer NO if you are not currently taking medications or other treatments)

3b. Do you have an irregular heart beat that requires medical management? (e.g. atrial fibrillation, premature ventricular contraction) YES NO

3c. Do you have chronic heart failure? YES NO

3d. Do you have diagnosed coronary artery (cardiovascular) disease and have not participated in regular physical activity in the last 2 months? YES NO

4. **Do you have High Blood Pressure?**
If the above condition(s) is/are present, answer questions 4a-4b. If NO, go to question 5.

4a. Do you have difficulty controlling your condition with medications or other physician-prescribed therapies. YES NO
(Answer NO if you are not currently taking medications or other treatments)

4b. Do you have a resting blood pressure equal to or greater than 160/90 mmHg with or without medication? YES NO
(Answer YES if you do not know your resting blood pressure)

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5. **Do you have any Metabolic Conditions?** *This includes Type 1 Diabetes, Type 2 Diabetes, Pre-Diabetes.* If the above condition(s) is/are present, answer questions 5a-5e. If NO, go to question 6.

5a. Do you often have difficulty controlling your blood sugar levels with foods, medications, or other physician-prescribed therapies? YES NO

5b. Do you often suffer from signs and symptoms of low blood sugar (hypoglycemia) following exercise and/or during activities of daily living? Signs of hypoglycemia may include shakiness, nervousness, unusual irritability, abnormal sweating, dizziness or light-headedness, mental confusion, difficulty speaking, weakness, or sleepiness.
YES NO

5c. Do you have any signs or symptoms of diabetes complications such as heart or vascular disease and/or complications, affecting your eyes, kidneys, OR the sensation in your toes and feet? YES NO

5d. Do you have other metabolic conditions (such as current pregnancy-related diabetes, chronic kidney disease, or liver problems?
YES NO

5e. Are you planning to engage in what for you is unusually high (or vigorous) intensity exercise in the near future? YES NO

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6. **Do you have any Mental Health Problems or Learning Difficulties?** *This includes Alzheimer's, Dementia, Depression, Anxiety Disorder, Eating Disorder, Psychotic Disorder, Intellectual Disability, Down Syndrome.* If the above condition(s) is/are present, answer questions 6a-6b. If NO, go to question 7.

6a. Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? YES NO
(Answer NO if you are not currently taking medications or treatments)

6b. Do you have Down Syndrome AND back problems affecting nerves or muscles? YES NO

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7. **Do you have a Respiratory Disease?** *This includes Chronic Obstructive Pulmonary Disease, Asthma, Pulmonary High Blood Pressure.* If the above condition(s) is/are present, answer questions 7a-7d. If NO, go to question 8

7a. Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? YES NO
(Answer NO if you are not currently taking medications or other treatments)

7b. Has your doctor ever said your blood oxygen level is low at rest or during exercise and/or that you require supplemental oxygen therapy? YES NO

7c. If asthmatic, do you currently have symptoms of chest tightness, wheezing, laboured breathing, consistent cough (more than 2 days/week), or have you used your rescue medication more than twice in the last week? YES NO

7d. Has your doctor ever said you have high blood pressure in the blood vessels of your lungs? YES NO

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8. **Do you have a Spinal Cord Injury?** *This includes Tetraplegia and Paraplegia.* If the above condition(s) is/are present, answer questions 8a-8c. If NO, go to question 9

8a. Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? YES NO
(Answer NO if you are not currently taking medications or other treatments)

8b. Do you commonly exhibit low resting blood pressure significant enough to cause dizziness, light-headedness, and/or fainting? YES NO

8c. Has your physician indicated that you exhibit sudden bouts of high Blood pressure (known as Autonomic Dysreflexia)? YES NO

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9. **Have you had a Stroke?** *This includes Transient Ischemic Attack (TIA) or Cerebrovascular Event.* If the above condition(s) is/are present, answer questions 9a-9c. If NO, go to question 10

9a. Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? YES NO
(Answer NO if you are not currently taking medications or other treatments)

9b. Do you have any impairment in walking or mobility? YES NO

9c. Have you experienced a stroke or impairment in nerves or muscles In the past 6 months? YES NO

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10. **Do you have any other medical condition not listed above or do you have two or more medical conditions?**
If you have other medical conditions, answer questions 10a-10c. If NO, Go to the PARTICIPANT DECLARATION page below.

10a. Have you experienced a blackout, fainted, or lost consciousness as a result of a head injury within the last 12 months OR have you had a diagnosed concussion within the last 12 months? YES NO

10b. Do you have a medical condition that is not listed (such as epilepsy, neurological conditions, kidney problems)? YES NO

10c. Do you currently live with two or more medical conditions? YES NO

PLEASE LIST YOUR MEDICAL CONDITION(S) _____
AND ANY RELATED MEDICATIONS HERE: _____

Go to the PARTICIPANT DECLARATION page below for recommendations about your current medical condition(s) and sign the PARTICIPANT DECLARATION.

If you answered NO to all of the follow-up questions about your medical condition, you are ready to become more physically active. Please sign the PARTICIPANT DECLARATION below:

> If is advised that you consult a qualified exercise professional to help you develop a safe and effective physical activity plan to meet your health needs. You are encouraged to start slowly and build up gradually - 20 to 60 minutes of low to moderate intensity exercise, 3-5 days per week including aerobic and muscle strengthening exercises. As you progress, you should aim to accumulate 150 minutes or more of moderate intensity physical activity per week. If you are over the age of 45 yr and NOT accustomed to regular vigorous to maximal effort exercise, consult a qualified exercise professional before engaging in this intensity of exercise.

If you answered YES to one or more of the follow-up questions about your medical condition:

> You should seek further information before becoming more physically active or engaging in a fitness appraisal.

PARTICIPANT DECLARATION

If you are less than the legal age required for consent or require the assent of a care provider, your parent, guardian or care provider must also sign this form.

I, the undersigned, have read, understood to my full satisfaction and completed this questionnaire, I acknowledge that this physical activity clearance is valid for a maximum of 12 months from the date it is completed and becomes invalid if my condition changes. I also acknowledge that a Trustee (such as my employer, community/fitness center, health care provider, or other designate) may retain a copy of this form for their records. In these instances, the Trustee will be required to adhere to local, national, and international guidelines regarding the storage of personal health information ensuring that the Trustee maintains the privacy of the information and does not misuse or wrongfully disclose such information.

Name:_____ Date: _____

Signature: _____ Date: _____

Signature of Parent: _____ Date:_____

Or Guardian (for participants under the age of majority)