SlowBurn®
PERSONAL TRAINING STUDIOS

Health History Information

Name:_____ Date:_____

Home Address:_____

City:_____ State:_____ Zip:_____

Work Address:_____

City:_____ State:_____ Zip:_____

Day Phone:_____ Eve. Phone:_____ Mobile:_____

E-mail Address(es):_____

Occupation: _____ Company:_____

Sex: Male___ Female ___ Height: ____ Weight: ____ Date of Birth: ____/_____/_____

3 favorite hobbies/interests: _____

If Applicable: Anniversary Date:_____ Children's Name(s) & Age(s): _____

_____

IN CASE OF EMERGENCY, WHOM SHOULD WE CONTACT?

Name:_____Phone: _____

Relationship:_____

Physician's name:_____ Phone:_____

HOW DID YOU HEAR ABOUT SERIOUS STRENGTH?

Friend	_____	Brochure	_____
Spouse	_____	Television	_____
Physician	_____	Radio	_____
Newspaper/Magazine	_____	Internet	_____
The Slow Burn Fitness Revolution (2003)	_____	Other	_____

CURRENT PHYSICAL ACTIVITY

TYPE	HOW OFTEN

1. Conditions

PLEASE CIRCLE ONE

If YES, supply as much detail as possible.

Do you have any history of heart problems?	No	Yes	
Do you have a current heart condition?	No	Yes	
Have you ever had a heart attack or stroke?	No	Yes	
Have you ever experienced chest pains?	No	Yes	
Do you have high or low blood pressure?	No	Yes	
Do you have arthritis?	No	Yes	
Do you have high cholesterol?	No	Yes	
Are you pregnant now or within the last 3 months?	No	Yes	
Any medical procedures within the last 12 months?	No	Yes	
Do you experience dizziness or fainting?	No	Yes	
Do you have asthma or any respiratory problems?	No	Yes	
Do you have Diabetes or a thyroid condition?	No	Yes	
Do you have or have you had a hernia of any kind?	No	Yes	
Are you taking any medications?	No	Yes	
Do you have a chronic illness or condition?	No	Yes	
Are you prone to headaches?	No	Yes	
Other?	No	Yes	

2. Injuries

PLEASE CIRCLE ONE

If YES, supply as much detail as possible.

Have you ever had any lower back problems?	No	Yes	
Do you have any neck problems?	No	Yes	

Do you have or have you had any other joint or muscle problems? (e.g. fibromyalgia)	No	Yes	

3. Other

PLEASE CIRCLE ONE

If YES, supply as much detail as possible.

Are you currently under the care of a physician for any reason at all?	No	Yes	
Do you smoke cigarettes, cigars, or other?	No	Yes	
Do you use drugs and/or alcohol?	No	Yes	
Are you taking any dietary supplements?	No	Yes	
Does your doctor know that you are beginning a new exercise program?	No	Yes	
If yes to the above question, does he/she object?	No	Yes	

Do you know of any other physical or mental condition that you have or have had that could be aggravated, worsened, exacerbated, inflamed, etc., by exercising or exerting yourself?

_____

_____

Please read this waiver in its *entirety* before signing. *Do not* sign this waiver if any part of it is not clearly understood:

I certify that the above statements are true and complete. Furthermore, I have had a medical examination within the last year that verified that I am in good health and able to participate in a strenuous physical conditioning program. I release Serious Strength, Inc., from all claims, injuries, damages, illnesses, actions or causes of action, and from all acts of active or passive negligence on the part of the company, corporation, club, its owners, solvents, agents, trainers, instructors, independent contractors or employees. I acknowledge that Serious Strength, Inc. will rely on my statements and representations.

Signature:_____ Date:_____

Witness:_____ Date:_____