5th Line Movement and Fitness

Name : _____ Date: Click here to enter a date.

Street Address: _____

City: _____ State: _____ Zip: _____

Phone: (h)_____ (w)_____ (c)_____

Email: _____

Best way to reach you: ☐home ☐work ☐cell ☐email

Age:_____ Birth Date: Click here to enter a date. Occupation: _____

Emergency contact name / phone: _____

Would you like to hear news about the studio and/or receive blog notices on topics such as fitness best-practices, nutrition, exercise safety, and general health information? ☐ Yes ☐ No

How did you hear about 5th Line Movement and Fitness? _____

Please answer the following questions:

Current regular physical activities: _____

Past physical activities you no longer do: _____

What benefits and/or goals are you looking to achieve? _____

Pregnant or nursing? ☐Yes ☐ No

Concerned with certain movements? _____

_____

Orthopedic problems (Arthritis or any other bone, joint or muscle problems) please explain:_____

_____

_____

Medications:_____

_____

Drug Allergies, Other Allergies: _____

_____

Please check the following that apply to you:

☐ I'm currently under the care of a physician or in a rehabilitation program.

☐ I have symptoms of cardiovascular disease which include and are not limited to pain in chest, neck, jaw, arms, shortness of breath at rest or during mild exertion, dizziness, ankle edema, irregular heartbeat or heart palpitations.

☐ I have painful symptoms not consistent with an orthopedic condition including but not limited to chronic fatigue with no obvious explanation, constant pain anywhere in the body unrelated to activity time or posture or persistent pain at night without any relief from position change or other activity.

If YES to the 1st, 2nd, or 3rd question above, OR you are over age 45 and answer yes to any of the questions below, please obtain medical clearance prior to starting an exercise program.

☐ I have fatigue with no obvious explanation, constant pain anywhere in the body unrelated to activity, time or posture, or persistent pain at night without relief with a change of position or a change of activity.

☐ I have high cholesterol (either LDL higher than 200 mg/dL or HDL less than 35mg/dL) and take statins.

☐ My mother, father brother and/or sister developed heart disease before age 50.

☐ I smoke cigarettes or have quit smoking cigarettes within the last two years.

☐ I have been physically inactive for the past 6 months or more.

☐ I have a history of heart disease

☐ I have diabetes

☐ I have a history of high blood pressure

☐ I have been diagnosed as obese

_____ I understand and agree that it is my responsibility to inform my practitioner of any conditions or changes in my health, now and ongoing, which might affect my ability to exercise safely and with minimal risk of injury.

_____ I also understand a minimum of 24 hours' notice is required to reschedule or cancel an appointment, and that if I reschedule or cancel less than 24 hours in advance of my appointment or fail to show for my appointment without any notice I will be charged the full price for the scheduled time.

I have read, understood, and completed this questionnaire to the best of my knowledge.

_____
Printed Name

_____ Click here to enter a date._____
Signature Date