PERSONAL INFORMATION

NAME:
DATE OF BIRTH: / /
ADDRESS:
GENDER:
SUBURB:
HOME PHONE:
POSTCODE:
WORK PHONE:
EMAIL:
MOBILE:
EMPLOYER:
OCCUPATION:
HAVE YOU EVER HAD A PERSONAL TRAINER NO ☐ YES ☐
WHERE DID YOU HEAR ABOUT EPIC WIN PT

MEDICAL CONTACT

DOCTOR'S NAME:
CONTACT PH:
ADDRESS:

EMERGENCY CONTACT

NAME:
CONTACT PH:
RELATIONSHIP:

WHAT DO YOU CONSIDER TO BE YOUR NUMBER ONE PRIORITY?

NAME TWO AREAS OF YOUR LIFE WHICH YOU ARE NOT HAPPY WITH RIGHT NOW AND WOULD LIKE TO IMPROVE?

WHAT HAS KEPT YOU FROM STARTING AN EXERCISE PROGRAM

☐	WORK	☐	PROCRASTINATION	☐	MONEY	☐	FAMILY COMMITMENTS
☐	TRANSPORT	☐	INJURY/ILLNESS	☐	ZOMBIES	☐	LACK OF MOTIVATION

Is this still a problem? YES / NO
Do your friends/family support you starting a program? YES / NO

CLIENT : .... **DATE** : ....

TRAINER : .... **DATE** : ....

MEDICAL QUESTIONNAIRE

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING

- ☐ Palpitations / Chest Pain
- ☐ Heart Condition
- ☐ Stroke
- ☐ Low or High Blood Pressure
- ☐ Blood Disorder
- ☐ Diabetes
- ☐ Liver / Kidney Conditions
- ☐ Stomach / Duodenal Ulcer
- ☐ Infectious disease
- ☐ Currently pregnant
- ☐ Epilepsy

If you have ticked any of the above, a medical certificate is required prior to commencing your exercise program in the interest of personal safety.

DOES YOUR FAMILY HAVE A HISTORY OF ANY OF THE ABOVE CONDITIONS?

....

....

HAVE YOU HAD ANY ILLNESSES IN THE LAST 12 MONTHS? IF YES, PLEASE GIVE DETAILS:

....

....

DO YOU HAVE ANY ALLERGIES?

....

....

DO YOU HAVE ARTHRITIS, ASTHMA OR HERNIA?

....

....

ARE YOU TAKING ANY PRESCRIBED MEDICATIONS? IF YES, PLEASE GIVE DETAILS:

....

....

It is important to discuss with your Doctor how these medications may affect your training program.

Are you receiving any treatment from a doctor, physio or other health professional? **NO** ☐ **YES** ☐

Have you been hospitalised recently or given birth in the last 3 months? **NO** ☐ **YES** ☐

Do you have, or have you had any joint, muscle pain or injuries? If yes, please give details.

NECK	NO ☐	YES ☐	....
BACK	NO ☐	YES ☐	....
SHOULDERS	NO ☐	YES ☐	....
HIPS	NO ☐	YES ☐	....
KNEES	NO ☐	YES ☐	....
ANKLES	NO ☐	YES ☐	....

DO YOU HAVE ANY OTHER MEDICAL PROBLEMS OR ISSUES WE SHOULD KNOW ABOUT BEFORE COMMENCING AN EXERCISE PROGRAM?

NO ☐ YES ☐

I have understood the questions above and my answers are true and correct. I accept that I will not have any claim against EPIC WIN PT or my instructor for any illness, injury or adverse change in medical condition arising directly or indirectly from any exercise program carried out.

CLIENT : .... **DATE** : ....

TRAINER : .... **DATE** : ....

CONDITIONS OF TRAINING DISCLAIMER

THIS IS AN IMPORTANT DOCUMENT THAT AFFECTS YOUR LEGAL RIGHTS AND OBLIGATIONS. PLEASE READ CAREFULLY AND DO NOT SIGN UNLESS YOU UNDERSTAND IT. IF YOU HAVE ANY QUESTIONS, PLEASE ASK.

This agreement is made between ___________________________ **(Trainer)** and ___________________________ (Client)

During your exercise program, every effort will be made to assure your safety. However, as with any exercise program, there are risks, including increased heart stress and the chance of musculoskeletal injuries. Part of your program will also include fitness testing which will enable a better assessment of your current fitness levels and provide a bench mark against normative tables to assist in setting realistic goals. By volunteering to participate in this program, you agree to assume the responsibility for these risks and waive any liability against **EPIC WIN PT** for personal damage.

Clearance from a medical practitioner is recommended for:

- All participants with any limiting physical conditions or disabilities or a history of medical conditions (as indicated in your lifestyle screening and pre exercise questionnaire forms, which must be completed prior to signing this agreement.)
- All men aged 45 and over and all women aged 55 and over
- If you fall into these categories and have not gained an examination prior to exercise, by signing this form you acknowledge that you are aware of this recommendation and its importance.

By signing below you accept full responsibility for your own health and wellbeing whilst participating in your exercise program with **EPIC WIN PT**. You acknowledge and understand that no responsibility is assumed by the personal trainer or **EPIC WIN PT** in regards to any injuries resulting from participation in this training program. It is recommended that all program participants work with their personal trainer three times per week. However due to scheduling conflicts and financial considerations a combination of supervised and unsupervised workouts are possible.

PERSONAL TRAINING TERMS AND CONDITIONS

1. Personal training sessions that are not rescheduled or cancelled 24 hours in advance may result in forfeiture of the session and a loss of the financial investment at the rate of one session.
2. Personal training clients arriving late will receive the remaining scheduled session time, unless other arrangements have been previously made with our personal trainer.
3. The expiration policy requires completion of all personal training sessions within 6 months from date of payment. Sessions are void after this time period.
4. No personal training refunds will be issued without the authorisation from management, including but not limited to relocation and unused sessions.
5. Payments for individual and group personal training session packages are required upfront.
6. Payment options include: cheque, cash or direct deposit.

SCHEDULED GROUP SESSIONS

1. Clients are required to book their place in all scheduled sessions to enable time to plan suitable sessions for each group and also ensure adequate equipment is brought for all participants.
2. It is recommended that class passes be pre purchased to avoid transactions prior to each session.
3. No refunds will be issued for any reason, including but not limited to relocation and unused sessions/classes.
4. All participants must sign this agreement form and a pre exercise questionnaire prior to participation.

LEGALLY BINDING AGREEMENT

You understand that this agreement is legally binding in its terms and conditions, whether your use of the facility and its services is determined and paid for on a monthly, yearly, or individual visit basis. This agreement constitutes the entire agreement between the parties with respect to the subject matter hereof and may be changed or added to only by a written amendment signed by both parties.

CLIENT SIGNATURE : .... **DATE :** ....

PARENT / GUARDIAN : .... **DATE :** ....

EPIC WIN PT SIGNATURE : .... **DATE :** ....

BODY COMPOSITION + POSTURAL APPRAISAL CONSENT FORM

I consent to the use or disclosure of my protected health information by the Assessor and/or Fitness Trainer for the purpose of analysing, diagnosing or providing recommendations of treatment to me. I understand that analysis and recommendations of treatment (if any) by the assessor may be conditioned upon my consent as evidenced by my signature below.

Due to the screening process (pre exercise screening questionnaire and medical clearance) and the nature of this assessment, the assessor will ask me to be in as minimal clothing as I feel comfortable. I understand that this is to ensure the most accurate assessment of my posture. Fatigue should not be excessive. Please inform the Assessor should any fatigue, pain or discomfort arise.

Information gained from this assessment will be used as the basis for exercise prescription and the design of a comprehensive exercise program. Details of this fitness assessment are strictly confidential and will only be given to your doctor or allied health professional by me, the client.

I am aware that my involvement in this fitness assessment procedure and subsequent exercise program is completely voluntary. I am also aware that I may request to stop any test or program prescription that I see fit, or to stop the assessment and/or program at any stage.

I have read this form and I understand the assessment procedure and consequent exercise program, which I will perform. I consent to participate in this fitness assessment and exercise program and I withdraw my right to make any claim whatsoever, against the Assessor and or/Fitness Trainer whom will conduct this fitness assessment and exercise program for any injury, illness or adverse change in my medical condition or state of health arising directly or indirectly from the tests, training or advice I have received from the Fitness Trainer before, during and after the fitness and subsequent exercise program.

CLIENT : .... DATE : ....

TRAINER : .... DATE : ....