Bull Dawg Athletic Training and Physical Therapy
5001-A Langston Boulevard, Suite 102 Arlington, VA 22207
Phone: 571-970-6068 | Email: info@bulldawgtraining.com

Personal Training Intake Forms

Date: _____ Date of Birth: _____

Last Name:_____ First Name: _____ Middle Name: _____

Weight: _____ Height: _____ Male: ( ) Female: ( ) Other: ( )

Home Address:_____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Number: _____

Email: _____

Physician's Name: _____

Phone Number: _____

Emergency Contact's Name: _____

Address:_____

Phone Number: _____

*Physical activity should not pose any problem or hazard to the majority of people. The following questions are designed to identify the small number of adults for whom physical activity might be inappropriate or those who should seek medical advice prior to initiating a fitness program or other change in their physical activity levels

1) Has your doctor ever told you that you have any of the following?:

____ Coronary heart disease
____ Rheumatic heart disease
____ Congenital heart disease
____ Irregular heartbeats
____ Heart valve problem
____ Angina
_____ Chest Pain
____ Heart Attack
____ Stroke
____ Epilepsy
____ Diabetes
____ Hypertension
____ Cancer

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If yes to any of the above, please explain: _____

_____

2) Medications: _____

_____

3) Do you now or in the past have/had any of the following?:

____Back pain ____ Soft tissue problems
____ Arthritis ____ Lung disease (asthma, emphysema, other)
____ Bursitis ____ Tendonitis
____ Dizziness ____ Depression
____ Joint, Tendon, or Muscular pain.

If yes to any of the above, please explain: _____

_____

4) Please list any medication that you are taking (name and reason)

_____

_____

_____

_____

5) Has any of your immediate family (mother, father, brother, sister had a heart attack or other heart related problems before the age of 50? _____

If yes, please explain: _____

_____

6) Are you currently under the supervision of a doctor? No ( ) Yes ( )

If yes, please explain: _____

_____

7) Do you have any medical condition for which your doctor has ever recommended some restriction on activity? No ( ) Yes ( )

If yes, please explain: _____

_____

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8) Are you pregnant? _____

9) Do you smoke? _____ If yes, # of cigarettes per day:_____

10) Did you ever smoke? _____ If yes, how long ago did you quit?_____

11) Do you drink alcoholic beverages at all?_____ Amount:_____

12) Do you have high cholesterol?
Below 200____ Above 200_____

13) Do you have High Blood pressure?_____ Date Last checked_____

14) Do you have ankle swelling?_____

15) Do you have shortness of breath?_____

16) Do you get lightheaded or faint?_____

17) Are you living a sedentary lifestyle?_____

18) When was your last physical?_____

19) Do you receive regular annual physical exams from your primary care physician?_____
Date of last Exam_____

20) Have you been hospitalized in the last two years? No ( ) Yes ( )

If yes, please explain:_____
_____
_____
_____

21) Please identify any pain, discomfort, known or previous injury to any of the following areas:

Area	**Side (left,right,both)**	**Please Explain**
Knee		
Shoulder		
Elbow		
Wrist		
Ankle		
Hip		

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History of Physical Activity

In the past three months how often have you been engaged in physical activity?

_____Regularly (3-4 times/week)_____Semi-regularly (1-2 times/week) _____Sporadic (1-2 times/month)_____Not at all

What are your personal barriers to exercise (i.e., reasons you do not exercise)?

_____
_____
_____
_____

Daily meals (List the food and drinks you consume on a regular basis. i.e. Diet cokes, pasta, hamburger, coffee, fruit, etc.)

_____
_____
_____

What, if any, physical activities have you liked and participated in regularly in the past?

_____
_____
_____
_____

Training Expectations/Goals:

Please specify what you would like to accomplish through your fitness program in the following time periods. Make sure your goals are **SMART: S**pecific, **M**easurable, **A**ttainable, **R**ealistic and **T**ime-Acceptable

6 months:

3 months:

1 month:

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I,_____, certify that I understand the foregoing questions and my answers are true and complete. I also understand that if this information changes in any way in the future, it is my responsibility to notify my personal trainer and that I assume the risk for any changes in my medical condition that might affect my ability to exercise.

Before beginning a new fitness program or other significant change in your physical activity levels, you are advised to consult with your physician or primary health care provider, only a physician or qualified health care provider is able to diagnose and prescribe treatment for specific health conditions. I acknowledge that I have read the foregoing statements and fully understand the content thereof, and that if I choose not to consult my physician or primary health care provider, I do so at my own risk.

Date: _____

Client name (Print): _____

Client Signature: _____

Parent/ Guardian Signature: _____

Trainer Signature: _____

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Waiver and Release of All Claims

The Client acknowledges that any exercise or fitness program involves risk of injury.

The Client represents that he/she has been recently examined by medical doctor and been found able to undertake a program of exercise.

For and in consideration of the fitness training sessions by Bull Dawg Athletic Training.,

Client agrees:

1. That any exercise program shall be undertaken by Client at his/her sole risk; and

2. That the Client understands that if they experience unusual pain or physical discomfort during participation in any activity, the Client will decrease or stop exercising and inform the instructor of the symptoms; and

3. That the Instructor/Trainer, Bull Dawg Training., shall not be liable to Client, nor any other person, for any claims or causes of action whatsoever arising out of or connected with the services of the above and

4. That Client hereby releases and discharges trainer and Bull Dawg Athletic Training and Physical Therapy from any such claims or actions.

By signing below, you agree to the above Waiver and Release of All Claims:

Name_____

Please print

_____ _____

(Signature of Client) Date

_____ _____

Legal Guardian's Signature *(if participant is under 18 years of age)* Date

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Policies Agreement Waiver

- Physician's Consent is required for men 45 and over and women 55 and over OR for anyone with a pre-existing medical condition prior to training.
- To cancel a training session, you must contact your trainer directly with **24 hours advance notice**, unless of an emergency. Sessions canceled with less than 24 hours notice will be **counted as used sessions**.
- Your sessions must be used within **six months** of your purchase date.
- Please wear exercise clothing to all sessions and assessments. Appropriate clothing includes athletic shoes, sweat pants, t-shirts, or shorts.
- Arrive on time to your scheduled appointment. Trainers will wait 15 minutes for late arrivals. After 15 minutes, the session will be counted as a "no show" and **count as a used session.**
- Sessions are approximately 50minutes.
- Sessions are **nonrefundable**.
- Fitness Assessment includes:

  Health history dialogue

  Blood pressure screening

  Baseline measurements (heart rate, body weight, etc.)

  Submaximal cardiovascular fitness testing

  Body Composition analysis

  Muscular Strength/Endurance assessment

  Flexibility assessment

  Goal Setting

By signing below, you agree to the above training policies:

Name: _____
Please print

_____ _____
Signature Date

_____ _____
Legal Guardian's Signature *(if participant is under 18 years of age)* Date