

Tim Williams/BodyGrades
Fitness Training services
10 Glenlake Plaza South Tower, Suite 130
Atlanta, GA 30328
Telephone: 678-316-9420

Personal Fitness Training Registration Form

Name _____ Sex _____ DOB _____ Age _____

Address _____ City _____ State _____
Zip _____

Cell Phone (____) ____ - _____ Home Telephone (____) ____ - _____

Email _____

PROGRAM POLICY

The purpose of this form is to serve as the initial request to begin personal or group fitness training services with Tim Williams, dba BodyGrades. Sessions will last 30-60 minutes, depending on agreed upon training time, as well as client's tolerance and safety. We reserve the right to stop a training session if a client's safety is at risk.

Please be on time for your appointments. If you are late for a session it will end at the scheduled time. If you are more than 15 minutes late for a session, it will be considered a no show and you will be assessed a session fee. (see cancellation policy below).

It is highly recommended that clients obtain a physical and a clearance from their physician prior to starting this or any other fitness program. If risks are identified, the client will be required to provide the trainer with an official physician's referral document stating that the client has been cleared to engage in a physical activity program.

PAYMENT POLICY

Sessions will be prepaid and will be due at the time of the initial appointment. Check, cash or credit card is accepted. Please make checks payable to 'Tim Williams' or 'BodyGrades.'

Session payments are non-refundable. Sessions are good up to 30 days after the last training session, unless extreme situations occur and approved in advance.

CANCELLATION POLICY

Sessions canceled less than 24 hours before the scheduled time will be charged for a full session unless the client experiences extreme circumstances. Extreme situations are at the discretion of the staff.

I acknowledge and fully understand the Program, Payment and Cancellation Policies as stated above.

Client Signature _____

Date _____

Client Name (print) _____

Training Representative _____

Date _____

NEW CLIENTS:

Agreed Upon Price: \$ _____ per ____ minute sessions per person, for ____ person(s) sessions.

If group sessions, please list names of other participants:

1) _____

2) _____

3) _____

Initial # of sessions: _____ **sessions. Days:** _____

Times: _____

Amount Paid \$ _____ **Date Paid** ____/____/____ **Check #** _____

Personal Training Program
Health/Medical History Questionnaire

**THIS FORM MUST BE COMPLETED BEFORE
ENGAGING IN PHYSICAL ACTIVITY**

Occupation: _____

Physician's Name: _____

Physician's Address: _____

Physician's Phone: (____) _____ - _____

HEALTH/FITNESS HISTORY

Are you presently involved in a regular exercise program? If yes, please list activity, duration, frequency and intensity:

Are you currently taking any medication regularly, including herbals, supplements and over-the counter drugs? ____ yes ____ no If yes please list type and reason:

Type: Reason:

Type: Reason:

Type: Reason:

Are you allergic to any medications? ____ Yes ____ No Medication:

Do you have or have you ever had any of the following conditions?

CONDITION DESCRIPTION

Heart Attack ____ yes ____ no

Shortness of breath ____ yes ____ no

Murmurs ____ yes ____ no

Stroke ____ yes ____ no

Seizures ____ yes ____ no

Chest Pain ____ yes ____ no

Hypertension ____ yes ____ no

Diabetes ____ yes ____ no

Cancer ____ yes ____ no

High Cholesterol ____ yes ____ no

Hernia ____ yes ____ no

Arthritis ____ yes ____ no

Joint swelling ____ yes ____ no

Emphysema ____ yes ____ no

Osteoporosis ____ yes ____ no

Rapid heart beat ____ yes ____ no

Thyroid ____ yes ____ no

Anemia ____ yes ____ no

Asthma ____ yes ____ no

Eating Disorder ____ yes ____ no

Musculoskeletal ___yes ___no

Disorder ___yes ___no

Emotional disorder ___yes ___no

Other ___yes ___no Have you experienced any of the following? (Recently= within the last month)

Recent illness ___yes ___no

Recent hospitalization ___yes ___no

New medical diagnoses ___yes ___no

Recent surgical procedure ___yes ___no

If yes, explain:

It is highly recommended that you consult with your physician prior to starting this or any other fitness activity.

Have you ever had or been injured in any of the following areas?

BODY PART DESCRIPTION WHEN

Neck ___yes ___no

Shoulders ___yes ___no

Arms ___yes ___no

Abdomen ___yes ___no

Back ___yes ___no

Legs ___yes ___no

What type of physical demands does your job impose on you?

Do you know of any physical condition that you have that could be aggravated by exercising or exerting yourself? ___yes ___no If yes, please explain

Do you now or have you ever smoked? ___yes ___no If yes previously smoked, how long did you smoke, how often and when did you quit?

If you currently smoke, how much?

Do you use recreational drugs? ___yes ___no If yes, how much (per day, week etc)

Do you use alcohol? ___yes ___no If yes, how much (per day, week etc)

Do you drink caffeinated beverages? (coffee, colas etc) ___yes ___no If yes, how many per day

Are you now or have you ever been on a diet? ___yes ___no If yes, explain

Number of meals you usually eat per day: _____

Do you consider yourself: (please circle): Sedentary Lightly Active Moderately
Active Highly Active

How would you describe your nutrition habits: (please circle): Good Fair
Poor

Would you characterize your life as: (please circle) Highly Stressful Moderately
Stressful Low in Stress

Please describe your knowledge of exercise and fitness: (please circle)

Very Knowledgeable Knowledgeable No Knowledge

Please list your personal fitness goals:

Please list a typical meal plan for the following:

Breakfast:

Lunch:

Dinner:

Snack:

Participation Agreement, Risk Assumption and Liability Release

I, _____ (print name), desire to participate in the physical fitness related activities and fitness programs of Tim Williams, dba BodyGrades, (BG). In consideration of being allowed to participate in these activities, I do hereby acknowledge and agree as follows:

1. I am fully informed and aware that my participation in these activities is completely voluntary. I understand that I have the right to independently decline or stop any activity, at any time and at my own discretion as I see fit. In addition, BG and its staff also has the right to stop any program, at any time, when the client's safety or the safety of others is at risk.
2. I am also aware that the physical fitness related activities and programs involve certain risks. These risks can be directly or indirectly related to the fitness activities. These risks include, but are not limited to, property damage and loss, bodily injury, illness and even death. **Knowing that, I fully assume all such risks and fully and forever release, waive and discharge, and covenant not to sue BG, (including, but not limited to, its trainers, trustees, staff, students, agents and/or its representatives) for any adverse events related to my participation in these activities.**
3. I (i) have read and fully understand this Agreement, (ii) intend that this agreement be legally binding and enforceable against me, my family, estate, heirs and legal representatives, (iii) confirm that I am at least 18 years of age, fully competent, and am entering into this Agreement voluntarily and of my own judgment and (iv) have been given adequate opportunity to ask questions as needed.

I have duly executed and delivered this Agreement as of _____, 20__.

Signature: _____

Print Name: _____

Emergency Contact Name and Phone No.:

