

Are you currently taking any medications?

If yes, please list medications and the dosage, and explain the condition.

Are you currently undergoing treatment from any of the following?

Physical Therapist _____ Chiropractor _____ Massage Therapist _____

If yes, why? _____

What is your current exercise level?

None _____ 2-3 times a week _____ 4-5 times a week _____

What type? _____

What do you think your ideal weight should be? _____

Have you ever been at your ideal weight? _____

If yes, when? _____

Are you currently on any type of special diet? _____

If yes, what type? _____

What are your exercise goals? Please number the following exercise benefits according to their importance to you. (one being most important)

Weight Loss _____ Weight Gain _____ Stress Reduction _____

Posture _____ Increase Strength _____

Cardiovascular Conditioning _____ Other _____

Estimate how many hours of sleep you get each night. _____

How would you rate your level of stress on a daily basis?

Low _____ Moderate _____ High _____

My signature below indicates that having read and understood the material above, I accept the risks associated with this fitness program and further do hereby release and hold harmless Premier Personal Training LLC, its employees, and owners from any and all liability for injury to my person, whether or not such liability is based on allegations of negligence.

Signature _____ Date _____