Membership Application

YOUR RESULTS ARE OUR BUSINESS.

Today's Date:

Touring Trainer:

Initial Consult:

On (day/date@time):

Personal Information:

First Name:

Last Name:

Street Address:

City, State:

Zip Code:

Work Phone:

Phone Home:

E-mail:

Cell Phone:

Birth Date (mm/dd/yyyy):

Age:

I prefer you to contact me via: ☐ work phone ☐ home phone ☐ e-mail ☐ cellular

In case of Emergency:

Please contact:

Phone:

Who may we thank for referring you:

Name/Phone/E-mail:

Waiver And Assumption of Risk:

I, ______________________________, hereby voluntarily sign this Waiver and Assumption of Risk in favor of F.I.T. (the "Company"), fully waiving and releasing the Company and its directors, officers, stockholders, employees and agents from any and all liability, claims for personal injury, causes of action, property damage, or death that may result from any negligent act committed by or on behalf of the Company, from my use of the Company's facilities or property, or from my participation in any of the "activities" or instruction provided or endorsed by the Company.

I sign this waiver and assumption of risk in consideration of the opportunity to use the Company's facilities or property, receive instruction from the Company and its employees, or to participate in Company-sponsored activities.

I acknowledge and understand that there are dangers and risks associated with the activities described above, which have been fully explained to me. I fully assume the dangers and risks, and agree to use my best judgement in engaging in those activities and to follow the safety instructions provided.

I am a competent adult and I freely and voluntarily assume the risks associated with the activities described above.

Signature:

Date:

Membership Application YOUR RESULTS ARE OUR BUSINESS.

Health Questionnaire

This medical assessment is required before you can begin your training. Please answer the following questions to the best of your ability.

Do you now, or have you had in the past: (circle answer)

Yes No History of heart problems, chest pain or stroke?

Yes No Any chronic illness or condition?

Yes No Advice from a physician not to exercise?4

Yes No Pregnancy (now or within the last 3 months)?

Yes No History of breathing or lung problems?

Yes No Muscle, joint, or back disorder, knee or any previous injury still affecting you?

Yes No Hernia or any condition that may be aggravated by lifting weights and exercising?

Yes No Do you know of any other reason not mentioned here, why you should not do physical activity?

Yes No Increased blood pressure?

Yes No Difficulty with physical exercise?

Yes No Recent surgery (last 12 months)?

Yes No History of breathing or lung problems?

Yes No Diabetes or thyroid condition?

If you answered YES to any of the above questions, please explain here:

Please list any health conditions which may affect your exercise program:

*Physicians or Physcial Therapist's name and phone#:

Food and Nutrition History:

While at its heart, F.I.T. is a school of fitness, we realize that nutritional support is a critical part of helping each individual reach his or her individual fitness, health, and physique goals. In addition to the focused, attentive training that you will receive at F.I.T., we encourage you to take seriously how you are fueling your efforts in and out of the gym. F.I.T. offers you the opportunity to work individually with experienced staff on creating an eating plan to help achieve your goals.

What, if anything, would you like to change about your eating habits?

Do you have any food allergies or sensitivities that you are aware of?

How many days per week do you eat the following and what do you typically eat at:

Breakfast:

Lunch:

Dinner:

How many hours of sleep do you typically get per night?
Is there a time of day that you typically experience low energy? If yes, what time?

Food and Nutrition History (Continued):

How often do you snack per day? 1x 2x 3x

When do you usually snack?

What are your common snacks?

Do you regularly eat out? How often?

Which restaurants/type of cuisine?

When you eat at home, who usually prepares the meals?

Who usually does the grocery shopping?

What do you look for on your food labels?

Is anyone in your household on a special diet?

Do you drink alcohol? How many drinks per week?

Do you regularly consume caffeinated drinks? If so, what do you typically drink and how many per day?

Do you take any vitamin, mineral, ergogenic aids or supplements?

What, if any, changes have you ever made to your diet to help enhance your performance?

What are your favorite foods?

Do you currently, or have you ever had, problems with:

Discomfort after eating Constipation Nausea Vomiting Diarrhea Falling Asleep Continuous Sleep

Weight History

How long have you been at your current weight?

What do you believe to be your optimal body weight?

What, if any, weight goals do you have?

Have you ever tried to lose weight? Y / N

Diet (specify) Weight Change How long did it last?

Diet (specify) Weight Change How long did it last?

(If more, continue on back of this sheet.)