



Client # \_\_\_\_\_

## Hi-Lo Strength Training Questionnaire & Consent Form

### General Information

Date \_\_\_\_\_ Name \_\_\_\_\_ Sex \_\_\_\_\_  
Birthdate \_\_\_\_\_ Age \_\_\_\_\_  
Address \_\_\_\_\_  
City/State/Zip \_\_\_\_\_  
Daytime Phone \_\_\_\_\_ Evening Phone \_\_\_\_\_  
Email (confidential) \_\_\_\_\_  
Present Employer \_\_\_\_\_  
How did you hear about us? \_\_\_\_\_  
What are your main concerns about your health that we may be able to help you with? \_\_\_\_\_

Would you like to receive our Quarterly E-Mail Newsletter YES / NO

### Phones (Circle the best number to reach you)

Home \_\_\_\_\_ Business \_\_\_\_\_ Cell \_\_\_\_\_  
Occupation \_\_\_\_\_  
In case of emergency, call Name \_\_\_\_\_  
Phone \_\_\_\_\_

### Personal Physician:

Name \_\_\_\_\_  
Address \_\_\_\_\_  
Phone \_\_\_\_\_

### Health Analysis

Circle Yes or NO. If yes, please explain

When was your last physical? Date \_\_\_\_\_

Are you under a physician's care now? Yes No Explain \_\_\_\_\_

Are you taking a physician prescribed or over the counter medications? Yes No Explain \_\_\_\_\_

Do you want me to coordinate your exercise program with a physician? Yes No Who? \_\_\_\_\_

Have you had any recent major illnesses? Yes No Explain \_\_\_\_\_

Have you had a major or minor (outpatient) surgery in the last 5 years? Yes No Explain \_\_\_\_\_

Do you have or have you ever had high or low blood pressure? Yes No Explain \_\_\_\_\_

Do you or any of your family have any history of aneurysms or sudden cardiac deaths? Yes No Explain \_\_\_\_\_

Are you under a physician's care, special diet, or medication? Yes No Explain \_\_\_\_\_

Do you experience frequent headaches? Yes No Explain \_\_\_\_\_

Do you have diabetes? Yes No Explain \_\_\_\_\_

Do you have low back or neck pain, tension or fatigue? Yes No Explain \_\_\_\_\_

Do you have any joint pain (shoulder, elbow, wrists, hips, ankles, etc.)? Yes No Explain \_\_\_\_\_

Are you aware of any abdominal hernias, or have you had one repaired in the past? Yes No Explain \_\_\_\_\_

Can you think of anything to add which I might need to know order to keep your exercise sessions safe and productive? \_\_\_\_\_  
\_\_\_\_\_

## **Exercise Goals and Concerns**

What exercise and/or recreational activities are you engaged in currently? \_\_\_\_\_

How would you rate your current level of physical fitness? \_\_\_\_\_

**Which exercise goals and/or results are most important to you?**

Circle all that apply

Fat loss/improved body shape

Increased muscular size/strength

Cardiovascular conditioning and health

Improved athletic performance

Relief from pain? Area

Physical rehabilitation

Increased muscular endurance/energy

Increased bone strength/density

Improved flexibility

The above statements are true and complete to the best of my knowledge, and hereby authorize Charles B. Christian, Jr. M.D. to release information to my physician, or to request from my physician any pertinent information regarding any physical condition that I have indicated above.

Signed \_\_\_\_\_ Date \_\_\_\_\_

Reviewed By Dr. Christian: Yes No CBC Initials: \_\_\_\_\_

Dr. Christian Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Dr.

Charles B.  
Christian, Jr.



\_\_\_\_\_ Date \_\_\_\_\_

STRENGTH TRAINING WAIVER AND RELEASE OF LIABILITY FORM

I, \_\_\_\_\_ (Client) agree that if I engage in any physical exercises including the use of any and all machinery, equipment, and apparatus designed for exercising, it shall be at my sole risk.

Client understands that the agreement to use, or selection of exercise programs, methods and types of equipment shall be the client's entire responsibility and the Company shall not be liable to the Client for any claims, demands, injuries, damages or actions arising due to injury to the Client's person or property arising out of or in connection with the use by the Client of the services, facilities and Company premises.

Client hereby holds the Company, its offers, owners, agents and employees harmless from all claims which may be brought against them by the Client or on the Client's behalf for any such injuries or claims.

I fully understand that I may injure myself as a result of my participation and I release Inside Outside Wellness Center and Medical Spa from any liability now or in the future, including but not limited to. Heart attacks, muscle strains, muscle pulls or tears, shin splints, heat exhaustion, knee or foot injuries, back injuries and any other illness, soreness or injury caused, occurring during or after my participation at Inside Outside Wellness Center and Medical Spa.

I affirm that I have read, understood and agree to the above:

---

Client's Signature

Date



**Voluntary Patient Disclaimer**  
**Regarding Pregnancy & DXA Scanning**  
(For Women Only)

I, \_\_\_\_\_, hereby state that I have been instructed by the staff of Inside Outside Wellness Center & Medical Spa that DXA Body Composition and Bone Densitometry testing is an elective procedure and that I must **NOT** have a DXA Scan performed if I am pregnant, or have any suspicion that I may be pregnant. I have instructed the staff of Inside Outside Wellness Center & Medical Spa that I am not pregnant, do not have any suspicion I may be pregnant, and I have elected to have this procedure performed today. Should it be determined at a later date that I am pregnant at the time the scan was performed, I agree to hold Inside Outside Wellness Center & Medical Spa, and any partners/affiliates of Inside Outside Wellness Center & Medical Spa, harmless from any liability and any potential future damages.

Signature:

\_\_\_\_\_

Date:\_\_\_\_\_