

# Hi-Lo Strength Training Client Intake Form

Date: \_\_\_\_\_ Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Client # \_\_\_\_\_

## General Information

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex:  M  F  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Preferred Phone: Cell Home Work Phone #: \_\_\_\_\_  
 Email: \_\_\_\_\_ Employer: \_\_\_\_\_  
 How did you hear about us?: \_\_\_\_\_  
 Would you like to receive our End of Year Newsletter and New Years Greeting?  Y  N  
 In case of Emergency: Call (Name): \_\_\_\_\_ Phone: \_\_\_\_\_  
 Personal Physician Name: \_\_\_\_\_

## Health Information

When was your last Physical? \_\_\_\_\_ Approximate Date (year): \_\_\_\_\_

Are you under a Physician's Care Now?:  Y  N Explain: \_\_\_\_\_

Are taking Prescription Drugs?  Y  N Describe: \_\_\_\_\_

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Are you taking OTC Drugs/Supplements  Y  N Describe: \_\_\_\_\_

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Have you any recent Major Illnesses?  Y  N Describe: \_\_\_\_\_

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Have you had a major or minor surgery in the past 5 Years?  Y  N Describe: \_\_\_\_\_

Do you have or have ever had high or Low Blood Pressure?  Y  N Describe: \_\_\_\_\_

Do you or your family have a history of Aneurysms or sudden cardiac death?  Y  N Describe: \_\_\_\_\_

Are you on a special diet?  Y  N Describe: \_\_\_\_\_

Do you have Frequent Headaches?  Y  N Describe: \_\_\_\_\_

Do you have Diabetes or take Insulin?  Y  N Describe: \_\_\_\_\_

Do you have low back or neck pain?  Y  N Describe: \_\_\_\_\_

Do you have joint pain (shoulder, knee Elbow, wrist or ankle)?  Y  N Describe: \_\_\_\_\_

Do you have any hernias or repair in past  Y  N Describe: \_\_\_\_\_

Can you think of anything to add which we need to know in order to keep your exercise Sessions safe? \_\_\_\_\_

# Hi-Lo Strength Training Client Intake Form P2

Date: \_\_\_\_\_ Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Client # \_\_\_\_\_

## 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?    Excellent    Good    Fair    Poor

## Which Exercise Goals and/or Results are most important to you?

- |  |                               |
|--|-------------------------------|
| Fat loss/improved body shape           | Increased Muscular Strength   |
| Cardiovascular Conditioning and health | Improved athletic performance |
| Relief from pain Area? _____           | Increased Flexibility         |
| Increased Bone Density                 | Improved Energy Levels        |

The above Statements are true and complete to the best of my knowledge , and I 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 that might affect the safety of the Hi-Lo Strength Training Program.

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

Signature of Parent if less than 18 years old: \_\_\_\_\_ Date: \_\_\_\_\_

Hi-Lo Strength Training Waiver and Consent Form Signed?    Yes    No

Reviewed by Dr. Christian:    Yes    No    CBC Initials: CBC

Dr. Christian Comments:    Cleared for Initial Exercise Evaluation    Not Cleared

Reason Not Cleared: \_\_\_\_\_

Need to Review with Primary Physician Before Proceeding?    Yes    No

Other Comments: \_\_\_\_\_

Comments after 1st Exercise Session:    No Issues Noted    Very Poor Strength  
Poor Coordination    Hearing Issues    Joint Limitations/Pain \_\_\_\_\_

Plan:    Hi-Lo Strength Training    Delay Training: \_\_\_\_\_

DXA Body Composition    Nutrition Prescription

Dr. Christian Signature: Charles B. Christian, Jr.

IO Form HiLo100 Revised 11/8/2022

## Strength Training Waiver and Release of Liability Form

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Client #: \_\_\_\_\_

I understand that if I engage in any physical exercises in the Inside Outside Strength Training Gym including the use of any and all machinery, equipment, and apparatus designed for exercising, it shall be at my sole risk.

I understand that this agreement to use, or selection of this exercise program, method and type of equipment shall be at my entire responsibility and that Charles B. Christian, Jr. M.D. dba Inside Outside Wellness Center & Medical Spa shall not be liable for any claims, demands, injuries, damages or actions arising due to injury to my person or property arising out of or in connection with the use by me of the services and facilities on the premises of Inside Outside Wellness Center & Medical Spa.

I hereby hold Inside Outside Wellness Center & Medical Spa, its offers, owners, agents and employees harmless from all claims which may be brought against them by me or on my 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 in exercise at Inside Outside Wellness Center & Medical Spa.

I understand that Charles B. Christian, Jr. M.D. is not a Physical Therapist or Rehabilitation Physician and does not have credentials which would allow him to provide Physical Therapy or Rehabilitation Services as part of the services he is offering me. None of his employees are credentialed to provide these types of services. If injuries occur or medical problems are worsened by the exercises, prompt referral will be made to their Primary Physician or to Physical Therapy and/or Rehabilitation Professionals. Clients will be allowed to return to Inside Outside when cleared by these professionals.

I understand that these exercise services are not covered by Dr. Christian's Medical Malpractice coverage and should not be considered Medical Services and are not covered by Medicare or Insurance.

I understand that Dr. Christian maintains a Nationwide Premier Businessowner's Liability Policy which covers the exercise facility.

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

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

IO Form HiLo101 Revised 11/4/2022

**Authorization & Informed Consent for  
Transmission of PHI & ePHI Via Possibly  
Unsecured Email, Internet, Text &  
Voice Communication Channels**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Client #: \_\_\_\_\_

I expressly request, authorize, direct, permit and unequivocally consent to Inside Outside Wellness Center & Medical Spa to transmit my Protected Health Information (PHI) and Electronic Protected Health Information (ePHI) to me via possibly unsecured text/voice message/internet cloud links/email.

I understand that Inside Outside Wellness Center & Medical Spa does not have the capability to completely guarantee that all text/voice messages and email/internet data are transmitted in an encrypted or secured format.

***I understand, however, in accordance with HIPPA Regulations, that Intake Documents, Consent Forms, Treatment Records, DXA Scan Results, Lab Results and other Identifiable PHI or ePHI will be stored in secured physical locations and/or HIPPA compliant encrypted cloud sites such as Sync.com. Therefore, PHI or ePHI can and will be sent to me, by virtue of this consent, by email/text via a HIPPA compliant encrypted link via Sync.com for download and personal use.***

I expressly waive any claims or rights with respect to transmission of some ePHI or PHI via possibly unsecured text/voice messages/email/internet. This could include Scheduling of appointments, Confirmation of appointments, Rescheduling appointments, Appointment reminders, Directions to our location, and post visit "Thank You" purposes. These communications might also include the nature of my appointment ie Spa Procedure, Botox Treatment and ALLE Reward Information, DXA Scan or Hi-Lo Strength Training, clarification of the appointment details, additional information about the service I received or reminders or instructions for post procedure care.

I fully understand that third parties may attempt to or actually access, use and disclose some PHI or ePHI stored and transmitted by HIPPA Compliant entities such as Inside Outside Wellness Center & Medical Spa and Sync.com to my mobile phone or desktop computer via text /voice message/email/internet.

I fully understand the risks of transmitting text/voice messages or email /internet containing PHI or ePHI and I am willing to accept those risks.

I knowingly, intentionally and voluntarily waive all rights, claims and damages relating to the negligence, breach of confidentiality or other tort and all other legal claims that could be asserted against Inside Outside Wellness Center & Medical Spa any of its employees, agents, members or otherwise as a result of any third person improperly accessing, using or disclosing my PHI or ePHI as a result of transmission via unsecured text/voice messaging, Internet or email.

Phone/Text Number: \_\_\_\_\_ Email: \_\_\_\_\_

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

**Form CL100 Auth Revised 9/19/2022**