



Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Occupation: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Phone (Home): \_\_\_\_\_ (Work): \_\_\_\_\_

Circle One:      Male      Female

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

The staff and management of **Fitness by Ina** believe that “motion” is basic to human life and that some degree of physical activity usually is possible for most individuals until death. Although all individuals perform some level of physical activity in their daily lives, certain levels of activity may have an adverse effect on individuals with any of the predisposing conditions listed previously.

If any of your answers to the following questions are “YES”, you should have a physical examination including an electrocardiogram done prior to beginning this exercise program.

And further, the undersigned hereby waives any right to file a claim for personal injury either in law or equity for any injuries received except as a result of the activity negligence of any instructor in the course herein. This release applies not only to Fitness by Ina, but to Ina Siegel or any of her associates of Fitness by Ina.

Acceptance of you as a (member, participant, student) is based upon the representations made by you (or your parent or guardian) in this informed consent.

\_\_\_\_\_  
SIGNATURE PARTICIPANT and/or GUARDIAN

\_\_\_\_\_  
DATE

- NO YES 1. Have you ever been advised by a doctor to avoid exercise? Explain:
- NO YES 2. Are you on any prescribed medications? List:
- NO YES 3. Do you, or have you ever smoked? Moderate or heavy? How long?
- NO YES 4. Do you, or have you ever had a breathing problem? Asthma? Explain:
- NO YES 5. Do you, or have you ever had a heart or lung problem? Explain:
- NO YES 6. Do you have any orthopedic problems? (bone, ligament, tendon, joint, muscles) Explain:
- NO YES 7. Do you, or have you ever had any back pain or problems? Explain:
- NO YES 8. Do you have any type of arthritis, bursitis, or tendonitis? Explain:
- NO YES 9. Do you have high blood pressure? Are you taking medication for it? List the type of medication.
- NO YES 10. Do you have any eating disorders or allergies? Are you on any  
UNSURE medication for it? Please list:
- NO YES 11. Are you under an extreme amount of stress? Explain:  
UNSURE
- NO YES 12. Are you on any special type of diet at the current time? Explain:
- NO YES 13. Do you, or have you recently had any injuries (including minor), or surgeries?
- NO YES 14. Is there history of any of the following conditions in your immediate blood relatives  
(i.e., parents, grandparents, siblings) CIRCLE:  
  
STROKE    DIABETES    CANCER    ASTHMA    ANEMIA  
NERVOUS CONDITION    HIGH BLOOD PRESSURE
- NO YES 15. How would you rate your current level of physical fitness? CIRCLE  
  
BEGINNER    INTERMEDIATE    ADVANCED
- NO YES 16. What do you currently do for physical fitness on a regular basis? Be specific:
- NO YES 17. How long has it been since you've been physically fit? Be specific:
- NO YES 18. What are your main reasons for enrolling in this program?