**Client Information** Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Gender:\_\_\_\_\_\_\_

Birthdate:\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Current Weight:\_\_\_\_\_\_\_\_\_lbs

Current Body Fat:\_\_\_\_\_\_\_\_\_%

Goal Weight:\_\_\_\_\_\_\_\_\_\_\_\_lbs

Goal Bodyfat:\_\_\_\_\_\_\_\_\_\_\_\_%

Activity Level

 Type:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Frequency:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_per day

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_per week

 Duration: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_minutes per session

 Specific Sport Goals:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician’s Orders/Health Conditions:

Medications:

Allergies:

Food Aversions Favorite Foods

**Present/Past History**
Have you had OR do you presently have any of the following conditions? (Check if yes.) \_\_\_ Rheumatic fever \_\_\_ Recent operation \_\_\_ Edema (swelling of ankles) \_\_\_ High blood pressure \_\_\_ Injury to back or knees \_\_\_ Low blood pressure \_\_\_ Seizures \_\_\_ Lung disease \_\_\_ Heart attack \_\_\_ Fainting or dizziness with or without physical exertion \_\_\_ Diabetes \_\_\_ High cholesterol \_\_\_ Orthopnea (the need to sit up to breathe comfortably) or paroxysmal (sudden, unexpected attack) nocturnal dyspnea (shortness of breath at night) \_\_\_ Shortness of breath at rest or with mild exertion \_\_\_ Chest pains \_\_\_ Palpitations or tachycardia (unusually strong or rapid heartbeat) \_\_\_ Intermittent claudication (calf cramping) \_\_\_ Pain, discomfort in the chest, neck, jaw, arms, or other areas with or without physical exertion \_\_\_ Known heart murmur \_\_\_ Unusual fatigue or shortness of breath with usual activities \_\_\_ Temporary loss of visual acuity or speech, or short-term numbness or weakness in one side, arm, or leg of your body \_\_\_ Other Family History Have any of your first-degree relatives (parent, sibling, or child) experienced the following conditions? (Check if yes.) In addition, please identify at what age the condition occurred. \_\_\_ Heart arrhythmia \_\_\_ Heart attack \_\_\_ Heart operation \_\_\_ Congenital heart disease \_\_\_ Premature death before age 50 \_\_\_ Significant disability secondary to a heart condition \_\_\_ Marfan syndrome \_\_\_ High blood pressure \_\_\_ High cholesterol \_\_\_ Diabetes \_\_\_ Other major illness:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Have you had a hormonal panel analysis?\_\_\_\_\_\_\_\_\_\_\_\_
Do you have a hormonal imbalance?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Do you have a history of seizures?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Do you have adverse reactions or low tolerance for stimulants?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Have you ever or are you currently taking beta-agonists?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Do you have a family history of diabetes?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Do you have a family history of high or low blood pressure?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Are you on hormonal birth control?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Have you ever used an anabolic/androgenic steroid?\_\_\_\_\_ If so, what specific timeframe did you use?\_\_\_\_\_\_\_\_\_ If so, what specific substance did you use?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Have you ever taken a diuretic (Over the counter or pharmaceutical?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Please list all supplements that you are currently using:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Waiver: I agree that all dietary/exercise programs shall be undertaken by me at my sole risk and that Autumn Cleveland shall not be liable to me for any claims, demands, injuries, health conditions, actions, or causes of action, whatsoever to my person or property arising out of or connected with the use by me of the services (diets/exercise programs) provided by Autumn Cleveland. I also hereby expressly forever release and discharge Autumn Cleveland from all claims, responsibilities, demands, injuries, damages, actions or causes of action, and from all acts of active or passive negligence on the part of Autumn Cleveland, such represented company, corporation, affiliated health club, its servants, agents, or employees. I, the client, represent and warrants that I am in good physical condition and that I have no health conditions, impairments, or ailment preventing me from engaging in active/passive exercise or dietary programs, or that will be detrimental or inimical to my health, safety, comfort or physical condition if I do so participate. To the best of my knowledge, the health information that I provided above is true. I understand that recommendations by Autumn Cleveland are not intended to prevent, heal, or cure any disease/condition. I also understand that Autumn Cleveland is not a certified/licensed/registered dietician and that I assume all responsibility in relation to her suggested diet/exercise programs, and that I am following these programs at my own risk.

Client Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Initial Price $\_\_\_\_\_\_\_\_\_\_\_\_ Revision Price $\_\_\_\_\_\_\_\_\_\_\_

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

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_