For Office Use Only – Entered & Date
Data _____
Health History_____

Company _____ **Employee/Spouse/Guest**

If Guest sponsored by _____

Name: _____

Street Address: _____ **City:** _____

State: _____ **Zip:** _____ **Age:** _____ **Date of Birth**:_____

Gender: *Male / Female* **Work Phone:** _____ **Cell Phone:** _____

Email: _____

1. What are your fitness goals?
   - ☐ Weight Loss
   - ☐ Tone/Firm
   - ☐ Weight Gain
   - ☐ Cardio Conditioning
   - ☐ Flexibility
   - ☐ Other (Please describe below)

2. What services are you interested in?
   - ☐ Group Personal Training
   - ☐ Specialty Small Group Training
   - ☐ Nutritional Guidance
   - ☐ One on one Coaching
   - ☐ Personal Training
   - ☐ Supplements

3. What are you currently doing as a workout program?

4. If not, when was the last time you worked out?

5. Is there anything specific we need to be aware of?

Check anything below you feel you need modifications for

- ☐ Running
- ☐ Throwing
- ☐ Sitting Up
- ☐ Squatting
- ☐ Pushing objects over your head
- ☐ Pushing objects away from your body
- ☐ Pulling Objects towards your body

423.902.0433 • 423.774.7944 • GetFit@DillardTraining.com
888.898.3874 Fax • www.DillardTraining.com • www.Facebook.com/DillardTraining

For Office Use Only – Entered & Date
Data _____
Health History_____

Name:_____

Informed Consent

By signing this document, I acknowledge that I have voluntarily chosen to participate in a program of progressive physical exercise known as Dillard Training. (Hereinafter referred to as the "program") By signing this document, I acknowledge that I have been informed of the strenuous nature of the program and the potential for unusual physiological results including, but not limited to abnormal blood pressure, fainting, heart attack or death.

By signing this document, I assume to the extent legally permissible, all responsibility and risk for my health and well being and hold harmless; Dillard Training, Bill Dillard , Patti Dillard, any trainer or assistant contracted by Dillard Training, Fit One Gym, McKee, MERC, Sunland Corporate Center, US Xpress, Hamilton County, The Well, Kenco Group, Cleveland Fitness Studios, Inc, EPB, Standifer Place Apartments, and NHE Property Management & Development from all damages or claims directly or indirectly resulting my participation in the program.

By signing this document, I give permission for Dillard Training to use any photographs and video taken that I am in to be used in any marketing, (i.e. print, flyers, Facebook, Twitter, YouTube, DillardTraining.com, etc.)

I understand that I am exercising at my own risk.

I understand that Dillard Training and Bill Dillard welcome and encourage questions about exercise procedures, recommendations and the Program.

_____

Signature **Date**

WAIVER

By signing this document, I acknowledge that I have been informed of the need to obtain a physician's examination of two or more risk factors are acknowledged as set for the in the Aerobic and Fitness Association of America's Standards and Guidelines and obtain approval prior to beginning the Program.

The risk factors are listed in paragraph 3 of the Program's required Health History Form which I have read completed and understand. I understand that I cannot participate in the program if I have two or more risk factors of Cardiovascular Disease until a Medical Release/Physician's approval is submitted to the Program staff. The program will be responsible for providing me with the necessary form and it will be my responsibility to submit this form to my Dr. and return it to Bill Dillard owner of Dillard Training prior to participation in the program.

_____

Signature **Date**

423.902.0433 • 423.774.7944 • GetFit@DillardTraining.com
888.898.3874 Fax • www.DillardTraining.com • www.Facebook.com/DillardTraining

For Office Use Only – Entered & Date
Data _____
Health History_____

Name:_____

Health History

Please provide the following information as accurately and completely as possible.

1. **Known Cardiovascular, Pulmonary or Metabolic Disease**
   Have you been diagnosed with any of the following diseases/disorders/conditions or had any of the following procedures?
   - □ Yes □ No Myocardial infarction ("heart attack")
   - □ Yes □ No Stroke or ischemic attack ("mini-stroke")
   - □ Yes □ No Heart bypass surgery or other heart surgery
   - □ Yes □ No Coronary catheterization and/or angioplasty
   - □ Yes □ No Abnormal ECG (tachycardias, heart blocks, etc.)
   - □ Yes □ No Other cardiovascular disease/disorder (aneurysm, etc.)
   - □ Yes □ No Asthma or chronic pulmonary disease (COPD, etc.)
   - □ Yes □ No Diabetes (insulin dependent, non-insulin dependent, etc.)
   - □ Yes □ No Hyperlipidemia (high LDL, low HDL, etc.)

   Comment: _____
   _____
   _____

2. **Signs or Symptoms Suggestive of Cardiovascular and Pulmonary Disease**
   Have you experienced any of the following?
   - □ Yes □ No Pain/discomfort in your chest, jaw or arms
   - □ Yes □ No Shortness of breath at rest or mild exertion
   - □ Yes □ No Dizziness or fainting spells
   - □ Yes □ No Difficulty breathing while lying down
   - □ Yes □ No Swelling of your ankles
   - □ Yes □ No "Skipped" heart beats or a "racing" heart beat
   - □ Yes □ No Occasional leg pain, especially while walking
   - □ Yes □ No Heart murmur
   - □ Yes □ No Fatigue or shortness of breath with usual activities

   Comment: _____
   _____
   _____

3. **Risk Factors of Cardiovascular Disease**
   Do you have a personal history of any of the following?
   - □ Yes □ No Cigarette smoking
   - □ Yes □ No Obesity or highly overweight
   - □ Yes □ No Physical inactivity
   - □ Yes □ No High blood pressure (over 140/90 mmHg) -- *Blood pressure* _____
   - □ Yes □ No High cholesterol (over 200 mg/dl) -- *Cholesterol* _____
   - □ Yes □ No Diabetes or high blood sugar (over 110 mg/dl) -- *Blood glucose* _____
   - □ Yes □ No Family history of heart attack/stroke, at young age

   Comment: _____
   _____
   _____

423.902.0433 • 423.774.7944 • GetFit@DillardTraining.com
888.898.3874 Fax • www.DillardTraining.com • www.Facebook.com/DillardTraining

For Office Use Only – Entered & Date

Data _____

Health History_____

Name:_____

4. **What is your current level of physical activity and exercise?**
(Frequency, duration, types of activity, etc.)

_____

_____

_____

5. **Other Information Concerning Personal Health History**
Do you have a personal history of any of the following?
Orthopedic diseases, disorders and/or conditions:

□ Yes □ No Arthritis (osteo or rheumatoid)
□ Yes □ No Joint pain or joint swelling
□ Yes □ No Joint surgery
□ Yes □ No Joint replacement
□ Yes □ No Low back pain
□ Yes □ No Osteoporosis ("low bone density")

Comment: _____

_____

_____

6. **Immunological / hematological diseases, disorders and/or conditions**

□ Yes □ No Cancer
□ Yes □ No Anemia
□ Yes □ No Immune disorders

Comment: _____

_____

_____

7. **Female specific conditions**

□ Yes □ No Pregnant (currently)
□ Yes □ No Amenorrhea (infrequent menstruation)
□ Yes □ No Menopause

Comment: _____

_____

_____

8. **Drugs/Medications**
Please list any prescription or over the counter (OTC) drugs/medications you are currently taking.
(Drug/Medication Purpose/Reason for Taking)

_____

_____

_____

423.902.0433 • 423.774.7944 • GetFit@DillardTraining.com
888.898.3874 Fax • www.DillardTraining.com • www.Facebook.com/DillardTraining

For Office Use Only – Entered & Date

Data _____

Health History_____

Name:_____

9. Doctor / Health Plan Information

Name / Group: _____

Phone / Fax: _____

Address: _____

_____

_____

10. In Case of Emergency *(Must be completed)*

Name: _____

Phone: _____

Note to Dillard Training® Participant

This health history information will be used to determine your "risk category" (as established by the

American College of Sports Medicine) for participation in any exercise program or exercise assessment associated with Dillard Training®. This information will be kept confidential to the extent provided by law and will be released to no other party other than your personal physician or primary care provider without your written consent. Depending on your "risk category" you may be asked to provide further Medical Clearance prior to specific exercise classes or fitness assessments or you may be excluded from participating in specific exercise classes or fitness assessments. If you are asked to provide further Medical Clearance, it will be kept on record for one year unless there is a change in your health and/or your ability to perform our exercise program.

Upon completion of this form, I declare and understand the following:

(Initial)

_____ I have completed this health history to the best of my recollection and have not knowingly withheld any information concerning my health history.

(Initial)

_____ I understand that this information will be used to assess my "risk category" for my participation in an exercise program and/or exercise assessment.

(Initial)

_____ I understand that I may be excluded from any exercise program and/or exercise assessment based on my exercise risk or that my participation may in some way be restricted or altered.

_____ _____

Signature ***Date***

If you require a **Physicians Release Form**, please notify your trainer and we can provide you with one or fax it to your physician.

423.902.0433 • 423.774.7944 • GetFit@DillardTraining.com
888.898.3874 Fax • www.DillardTraining.com • www.Facebook.com/DillardTraining