



## Under 18 - Corporate

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



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

### Under 18 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.**

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Printed Name

Date

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Signature

Date

**Parent or Guardian Signature (required for participant under the age of 18)**

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Printed Name

Date

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Signature

Date

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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:** \_\_\_\_\_



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

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**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:** \_\_\_\_\_

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

- Yes  No Cancer
- Yes  No Anemia
- Yes  No Immune disorders

**Comment:** \_\_\_\_\_

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**7. Female specific conditions**

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

**Comment:** \_\_\_\_\_

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**8. Drugs/Medications**

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

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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.