

Rialto Wellness Boot Camps

CLIENT INFO

Price of program \$ _____

Session Location _____

Please check the session you're signing up for:

- | | |
|--|--|
| <input type="checkbox"/> M - W - TH @ 6:00am | <input type="checkbox"/> M - W - TH @ 6:00pm |
| <input type="checkbox"/> M - W - TH @ 7:30am | <input type="checkbox"/> T - TH @ 12:30pm |
| <input type="checkbox"/> M - W - TH @ 9:00am | <input type="checkbox"/> T - TH @ 5:30am |

PERSONAL/HEALTH

Reminder: Print, sign and bring Waiver Consent Form; bring to 1st session

Name _____

Address _____

Home # _____ Office # _____ Cell # _____ Email _____

DOB _____ Age _____ Height/Weight _____

Have you exercised in the past 6 months? Yes No

Type? _____ Duration? _____

What are your current eating habits?

Do you smoke? Yes No If yes, how many cigarettes or packs per week?

Do you drink? Yes No If yes, how many alcoholic beverages per week?

Please list any medications you are taking:

Health Assessment: Please check if you have or have had any of the following.

- | | | |
|---|--|--|
| <input type="checkbox"/> Heart attack | <input type="checkbox"/> Cardiac catheterization | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Hernia | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Coronary bypass surgery | <input type="checkbox"/> Stroke | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Chest pain or angina | <input type="checkbox"/> Pregnant (last 3 mos.) | <input type="checkbox"/> Loss of consciousness |
| <input type="checkbox"/> Angioplasty | <input type="checkbox"/> Asthma | <input type="checkbox"/> Any recent surgeries |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Limitations of movement | <input type="checkbox"/> Knee problems/surgeries |
| <input type="checkbox"/> Difficulty breathing | <input type="checkbox"/> Back problems/surgeries | <input type="checkbox"/> Shoulder problems |
| <input type="checkbox"/> Irregular heart beat/rhythm thought to be significant by a physician | | |

If you answered yes to any of the above questions, please explain in further detail:

Emergency Care:

Contact Name: _____ Phone: _____

I hereby certify that I have disclosed in writing to the staff of Rialto Wellness any known physical or mental illness or weakness that would increase the risk to me of participation in exercise. I do hereby declare myself to be physically sound and suffering from no condition, impairment, disease, infirmity or other illness that would prevent or impair my participation in any of the activities associated with the fitness training programs offered by Rialto Wellness. I do hereby assume all responsibility for my actions and physical conditions, including injuries, arising from my participation in any Rialto Wellness activity.

Please sign and date