



Client Information

Name: _____ Date of Birth: _____

Address: _____

Home Phone: _____ - _____ Work Phone: _____ - _____

Cell: _____ - _____ E-Mail: _____

Occupation: _____ Referred by: _____

In case of emergency: _____ Phone: _____ - _____

General & Medical Information:

If you answer "yes" to any of the following questions, please explain as clearly as possible.

- | | |
|---|---|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Have you ever participated in a group fitness class? | <input type="checkbox"/> Yes <input type="checkbox"/> No Have you had any broken bones in the past two years? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Do you experience frequent headaches? | <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have tension or soreness in a specific area? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Are you pregnant? | <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have cardiac or circulatory problems? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Are you wearing contact lenses? | <input type="checkbox"/> Yes <input type="checkbox"/> No Do you suffer from back pain? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Are you diabetic? | <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have numbness or stabbing pains anywhere? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have high blood pressure? | <input type="checkbox"/> Yes <input type="checkbox"/> No Are you very sensitive to touch / pressure in any area? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No If yes to the previous question, are you taking medication for this? | <input type="checkbox"/> Yes <input type="checkbox"/> No Have you ever had surgery? If yes, please explain. |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Do you suffer from seizure disorders or epilepsy? | <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have any other medical condition that I should be aware of? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Do you suffer frequently from stress? | <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have any allergies? If yes, please explain. |

Comments: _____

Fitness & Physical Activity:

Activity/Sport:	Duration: (per session)	Frequency: (per week)	No. of Years:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

WAIVER AND RELEASE

LifeThyme Wellness

I intend to use some or all of the activities, facilities, programs and services offered at or by *LifeThyme Wellness*. In consideration of being allowed such use, I do hereby waive, release and forever discharge *LifeThyme Wellness* and its officers, employees, agents, representatives and all others acting on its behalf from any and all claims or causes of action (known or unknown) for any and all injury, illness, damage or loss that may occur to me or my property as a result of my participation in any aspect of the activities, facilities, programs and services offered at or by *LifeThyme Wellness*, including, but not limited to, my use of equipment or machinery in connection with the activities, facilities, programs and services offered at or by *LifeThyme Wellness*.

I understand that each person (myself included) has a different capacity for participating in such activities, facilities, programs and services. I am aware that all activities, facilities, services and programs offered are either, educational, recreational or self-directed in nature. I agree that my participation in any and all of the activities, facilities, programs and services provided at or by the *LifeThyme Wellness* is strictly voluntary. I further agree that my participation in any and all activities, facilities, programs and services provided at or by the *LifeThyme Wellness* is at my own risk and that I assume any and all risk of injury, illness, damage or loss that might result. I also agree to assume all risk of damage, loss or theft to or of any of my personal property.

I declare myself to be physically sound and suffering from no condition, impairment, disease, infirmity or other illness that would prevent my participation in any of the activities, facilities, programs and services offered at or by *LifeThyme Wellness*. I acknowledge that I have either had a physical examination and have been given a physician's permission to participate in these activities, facilities, programs and services, or that I have decided to participate in these activities, facilities, programs and services without the approval of my physician. I do hereby assume all responsibility for my participation in the activities, facilities, programs and services offered at or by *LifeThyme Wellness* and for my utilization of any and all equipment and machinery in connection with these activities, facilities, programs and services.

I understand that the activities, facilities, programs and services offered by *LifeThyme Wellness* may sometimes be conducted by persons who may not be knowledgeable, licensed, certified or registered instructors or professionals. I accept the fact that the skills and competencies of some *LifeThyme Wellness* employees, agents, representatives or volunteers will vary according to their training and experience and that no claim is made to offer assessment or treatment of any mental or physical disease or condition by those who are not duly licensed, certified or registered and employed to provide such professional services.

Signature

Date

Print Name

LifeThyme Wellness