Confidentiality Agreement

Arise in Motherhood
EMPOWERING MAMAS, STRENGTHENING LIVES

Participant

Name: _____

Date of Birth: _____ Email: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Primary Phone Number: _____

Please read the below statement and sign where indicated.

Statement

I understand that the information collected by **Arise in Motherhood** will be used for fitness evaluation purposes and for the design, implementation, progression, and maintenance of an individualized fitness program only. I further understand that all such information is confidential and will not be shared with anyone without my prior written authorization, except in the case of a medical emergency or to the minimum extent necessary to achieve a safe and effective fitness program.

Signature

Print Name: _____ Signature: _____

Date Signed: _____

If participant is under 18: As Parent or Legal Guardian of _____, I consent to his / her participation in the physical evaluation program conducted by **Arise in Motherhood**.

Print Name: _____ Signature: _____

Date Signed: _____

Fitness Liability Waiver

Arise in Motherhood
EMPOWERING MAMAS, STRENGTHENING LIVES

Participant Information

Name: _____

Date of Birth: _____ Email: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Primary Phone Number: _____

Emergency Contact

Name: _____ Relationship: _____

Phone Number: _____

Do you have any physical limitations that could be aggravated by exercise (e.g., back, neck, shoulder, or knee problems)?
☐ Yes ☐ No

If so, please explain: _____

Responsibility and Waiver

It is my responsibility to inform my trainer of any physical limitations before beginning a training program.

I represent and warrant that I am in good physical health and do not suffer from any medical condition that would limit my participation in training offered by Arise in Motherhood. I understand that it is **my responsibility** to consult with a physician prior to and regarding my participation in any fitness training or group training. I understand the risks associated with the activities offered by Arise in Motherhood and I agree to follow all instructions so that I may safely participate in training, workshops, or other activities.

I hereby **WAIVE AND RELEASE** Arise in Motherhood from any claim, demand, or cause of action of any kind resulting from or related to my participation in the programs offered by Arise in Motherhood. In taking part in fitness training or group training with Arise in Motherhood, I **understand and acknowledge** that I am fully responsible for any and all risks, injuries, or damages, known or unknown, which might occur as a result of my participation in fitness training or group training.

Signature

I have read the above release and waiver of liability and fully understand its content. I am legally competent to sign and voluntarily agree to the terms and conditions stated above.

Print Name: _____ Signature: _____

Date Signed: _____

If participant is under 18: As Parent or Legal Guardian of _____, I consent to the above terms and conditions.

Print Name: _____ Signature: _____

Date Signed: _____

Health History Questionnaire

Arise in Motherhood
EMPOWERING MAMAS, STRENGTHENING LIVES

Participant Information

Please print your answers clearly.

Name: _____ Date of Birth: _____ Age: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____

Employer: _____ Occupation: _____

Emergency Contact

Name: _____ Relationship: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____

Physician Information

Name: _____ Phone: _____

Are you under the care of a physician, chiropractor, or other health care professional for any reason? ☐ Yes ☐ No

If Yes, list reason: _____

Are you taking any mediations? ☐ Yes ☐ No

If Yes, please list:

Medication	*Dosage*	*Frequency*	*Condition*

List any and all allergies: _____

Has your doctor ever diagnosed you with high blood pressure? ☐ Yes ☐ No

Has your doctor ever diagnosed you with a bone or joint problem that has been or could be made worse by exercise? ☐ Yes ☐ No

Are you over 65 years of age? ☐ Yes ☐ No

Are you used to vigorous exercise? ☐ Yes ☐ No

Medical Information

Please answer the following questions:

Have you experienced any chest pain associated with either exercise or stress? ☐ Yes ☐ No

If Yes, please explain: _____

Have you experienced any shortness of breath with or without exercise? ☐ Yes ☐ No

If Yes, please explain: _____

Have you experienced fainting or light-headedness? ☐ Yes ☐ No

If Yes, please explain: _____

Have you had a recent hospitalization for any cause? ☐ Yes ☐ No

If Yes, please explain: _____

Do you have any orthopedic conditions (including arthritis)? ☐ Yes ☐ No

If Yes, please explain: _____

Have you ever experienced a rapid heartbeat or palpitations? ☐ Yes ☐ No

If Yes, please explain: _____

Is there any reason why you should not follow a regular exercise program?? ☐ Yes ☐ No

If Yes, please explain: _____

Please indicate if a blood relative (parent, sibling, first cousin, etc.) has a history of any of the following conditions. If there is a family history for any condition, please check the box to the left, and on the right, list who in the family has or had this condition.

☐ Asthma: _____

☐ Respiratory/Pulmonary Conditions: _____

☐ Diabetes: _____

☐ Type I ☐ Type II How long? _____

☐ Epilepsy: _____

☐ Petite Mal ☐ Grand Mal ☐ Other

☐ Osteoporosis: _____

☐ Coronary Artery Disease: _____

☐ Heart Attack: _____

☐ Hypertension: _____

☐ High Blood Pressure: _____

☐ Stroke: _____

Lifestyle Habits

Please check the box that describes your current habits:

Do you smoke? ☐ Yes ☐ No If yes, how often: _____

☐ Former user Date quit: _____

☐ 1 or fewer cigarettes per day

☐ 2 to 5 cigarettes per day

☐ 6 to 10 cigarettes per day

☐ More than 10 cigarettes per day

Do you drink caffeine? ☐ Yes ☐ No If yes, how often: _____

☐ Several times a day List below the types of caffeinated beverages you consume.

☐ Once per day _____

☐ Few times per week

☐ Few times per month

Do you drink alcohol? ☐ Yes ☐ No If yes, how often: _____

☐ Several times a day

☐ Once per day

☐ Few times per week

☐ Few times per month

On average, how many hours of sleep do you get each night?

☐ More than 10 hours
☐ 8-10 hours
☐ 5-7 hours
☐ Less than 5 hours

On average, what is your energy level like each day?

☐ High energy
☐ Moderate energy
☐ Low energy

Dietary Factors

Please indicate if you personally have a history of the following:

Anemia:	☐ Yes	☐ No	Thyroid Disorder:	☐ Yes	☐ No
Gastrointestinal Disorder:	☐ Yes	☐ No	Pre/Postnatal:	☐ Yes	☐ No
Hypoglycemia:	☐ Yes	☐ No			

Cardiovascular

Please indicate if you personally have a history of the following:

High Blood Pressure:	☐ Yes	☐ No	Heart Attack:	☐ Yes	☐ No
Hypertension:	☐ Yes	☐ No	Stroke:	☐ Yes	☐ No
High Cholesterol:	☐ Yes	☐ No	Bypass or Cardiac Surgery:	☐ Yes	☐ No
Hyperlipidemia:	☐ Yes	☐ No	Angina:	☐ Yes	☐ No
Heart Disease:	☐ Yes	☐ No	Gout:	☐ Yes	☐ No
Skipped Heartbeat:	☐ Yes	☐ No	Phlebitis or Embolism:	☐ Yes	☐ No

Other: Please explain: _____

Please list any other diagnosed conditions and the dates of diagnoses below:

Condition	*Date Diagnosed*	*Condition*	*Date Diagnosed*	*Condition*	*Date Diagnosed*

Pain History

Please indicate if you have or have had pain in the following. If checked, please describe.

☐ Head/Neck:		☐ Hip/Pelvis:	
☐ Upper Back:		☐ Thigh/Knee:	
☐ Shoulder/Clavicle:		☐ Arthritis:	
☐ Arm/Elbow:		☐ Hernia:	
☐ Wrist/Hand:		☐ Surgeries:	
☐ Lower Back:		☐ Other:	

Nutrition

Please answer the following questions:

Are you on any specific food/diet plan? ☐ Yes ☐ No

If Yes, please list and advise who prescribed it: _____

Do you take dietary supplements? ☐ Yes ☐ No

If Yes, please list: _____

Do you notice your weight fluctuating? ☐ Yes ☐ No

Have you experienced recent weight gain or loss? ☐ Yes ☐ No

If Yes, explain how: _____ Over what amount of time?

How would you describe your current nutritional behaviors? _____

List any other food/nutritional issues you want to include (food allergies, mealtimes, etc.).

_____

Work and Environment

Please check the box that best describes your work and exercise habits.

☐ Intense occupational and recreational effort

☐ Moderate occupational and recreational effort

☐ Sedentary occupational and intense recreational effort

☐ Sedentary occupational and moderate recreational effort

☐ Sedentary occupational and light recreational effort

☐ Complete lack of activity

How stressful are your environments?

Work:	☐ Minimal	☐ Moderate	☐ Average	☐ Extremely
Home:	☐ Minimal	☐ Moderate	☐ Average	☐ Extremely

Do you work more than 40 hours a week? ☐ Yes ☐ No

List anything else you would like your trainer to know.

_____

Signature

Print Name: _____ Signature: _____

Date Signed: _____

Print Name: _____ Signature: _____

Date Signed: _____

Informed Consent

Arise in Motherhood
EMPOWERING MAMAS, STRENGTHENING LIVES

Participant

Name: _____

Date of Birth: _____ Email: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Primary Phone Number: _____

Please fill out all information requested below.

Benefits

Participation in a regular program of physical activity has been shown to produce positive changes in a number of organ systems. These changes include increased work capacity, improved cardiovascular efficiency, and increased muscular strength, flexibility, power and endurance.

Risks

I recognize that exercise carries some risk to the musculoskeletal system (sprains, strains) and the cardiorespiratory system (dizziness, discomfort in breathing, heart attack). I hereby certify that I know of no medical problem (except those noted below) that would increase my risk of illness and injury as a result of participation in a regular exercise program.

Testing and Evaluation Results

I understand that I will undergo initial testing to determine my current physical fitness status. The testing will consist of completing this health inventory, taking a step test or bicycle ergometer test for cardiovascular fitness, and being tested for muscular fitness and body composition.

I further understand that such screening is intended to provide Arise in Motherhood with essential information used in the development of individual fitness programs. I understand that my individual results will be made available only to me. I also understand that the testing is not intended to replace any other medical test or the services of my physician. I will be provided a copy of all test results. I may share the results with whomever I please, including my personal physician. By signing this consent form I understand that I am personally responsible for my actions during my tenure at Arise in Motherhood, and that I waive the responsibility of this center if I should incur any injury as a result of my negligence.

Signature

I hereby give my consent to participate in the physical fitness evaluation program conducted by Arise in Motherhood.

Print Name: _____ Signature: _____

Date Signed: _____

If participant is under 18: As Parent or Legal Guardian of _____, I consent to his / her participation in the physical evaluation program conducted by Arise in Motherhood.

Print Name: _____ Signature: _____

Date Signed: _____

Physical Activity Readiness Questionnaire

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EMPOWERING MAMAS, STRENGTHENING LIVES

Regular physical activity is part of a healthy, balanced lifestyle. If you are planning to become more physically active, start by answering the following questions. Individuals of any age should check with their doctor before beginning a fitness program. This questionnaire is designed for people aged 15 to 70.

Please answer the following questions honestly with a Yes or a No:

☐ Yes	☐ No	Has your doctor ever diagnosed you with a heart condition AND told you to only do physical activity they can supervise?
☐ Yes	☐ No	Does your doctor currently prescribe you drugs for your blood pressure or heart condition?
☐ Yes	☐ No	Do you feel chest pain during physical activity?
☐ Yes	☐ No	Do you lose your balance due to dizziness OR have you lost consciousness in the last 12 months?
☐ Yes	☐ No	Do you have a bone, joint, or soft tissue problem that may be irritated by physical activity?
☐ Yes	☐ No	In the past 30 days, have you had chest pain at any point?
☐ Yes	☐ No	Do you have any other reason to NOT do physical activity?

If you answered Yes to one or more questions:

Talk to your doctor BEFORE you begin physical activity and BEFORE completing any fitness assessment. Discuss the questions you answered YES to with your doctor. Find out what activity you are cleared to partake in and any next steps your doctor wishes you to take.

If you answered No to all questions:

If you answered NO honestly to all questions, you may:

- Become more physically active; start slowly and build up gradually.
- Take part in fitness assessments.
- Consult with a fitness professional for guidance

DELAY becoming more active:

- If you are not feeling well
- If you are or may become pregnant
- If your health suddenly changes

SIGN and RETURN a copy of this form to info@aimfitness.online

I have read, understood to my satisfaction, and completed this questionnaire. I acknowledge that **Keni Loud, CPT** may retain a copy of this form for her records and it will be kept with confidentiality in compliance with applicable laws.

Print Name _____ Signature _____

Date Signed _____ Witness _____

Signature of parent/guardian/care provider (if applicable) _____

NOTE: The PAR-Q is intended to be completed prior to participation in a fitness assessment or physical activity. This activity clearance is valid for 12 months from the date completed and becomes INVALID should your health change and you may answer Yes to any of the above questions.