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# Health and Medical History and Consent and Release

Name: _____ Date: _____

Date of Birth: _____

Street Address: _____

City/State/Zip: _____

Phone: Home: _____ Work: _____ Cell: _____

Email address" _____

***Emergency contact***: Name / Relationship: _____ Phone: _____

Physical activity should not pose any problem or hazard to the majority of people. The following questions are designed to identify the small number of adults for whom physical activity might be inappropriate or those who should seek medical advice prior to initiating a fitness program or other change in their physical activity levels. Please check Yes or No.

| Yes | No | |
|---|---|---|
| ___ | ___ | 1. Are you accustomed to vigorous exercise? |
| ___ | ___ | 2. Have you ever been diagnosed with Type I or Type II Diabetes? |
| ___ | ___ | 3. Do you have any reason to suspect that you might now pregnant, or have you been pregnant within the last 3 months? |
| ___ | ___ | 4. Have you had any major or minor surgery in the past 3 months? |
| ___ | ___ | 5. Have you been hospitalized in the last 2 years? If so, when and for what reason? _____ |
| ___ | ___ | 6. Are you currently, or have you in the past, ever seen a chiropractor or physical therapist for any condition? If yes, when and for what condition? _____ |
| ___ | ___ | 7. Do you ever experience unexpected shortness of breath, or labored breathing, with or without pain? If yes, describe under what conditions. _____ |
| ___ | ___ | 8. Do you currently, or have you ever, experienced unexplained heart palpitations or been diagnosed with a heart murmur or irregular heartbeat? |

___ ___ 9. Have you ever been diagnosed with high blood pressure? If yes, when?_____

___ ___ 10. Do you know what your blood pressure normally is? If yes, please state _____

___ ___ 11. Do you currently smoke? If yes, how many cigarettes per day?_____

___ ___ 12. Did you ever smoke? If yes, how long ago did you quit?

___ ___ 13. Is there any history of heart disease (prior to age 55) in your immediate family? If yes, explain.

_____

___ ___ 14. Do you know your cholesterol levels? If so, please state: _____

___ ___ 15. Do you receive regular annual physical exams from your primary care physician? Date of last exam: _____

___ ___ 16. Do you have any pain, discomfort?
If you checked "Yes," explain where and how long you have experienced such pain or discomfort.

_____

_____

Are there any other health/medical/injury conditions that your MAT Specialist should be aware of?

_____

Please list any prescription medications or over-the-counter medications or supplements you currently take:

_____

## ***RELEASE / DISCLAIMER***

**I DO HEREBY ASSUME FULL RESPONSIBILITY FOR ANY AND ALL DAMAGES, INJURIES (INCLUDING DEATH), OR LOSSES THAT I MAY SUSTAIN OR INCUR, IF ANY, WHILE ATTENDING, PRACTICING OR PARTICIPATING IN ANY EXERCISE PROGRAM OR PHYSICAL ACTIVITY OCCURING IN OR ABOUT THE STUDIO. I HEREBY ASSUME FULL RISK, WAIVE ALL CLAIMS AND RELEASE AND HOLD CORE RESORE, LLC, ITS OWNERS, INSTRUCTORS, CONTRACTORS OR EMPLOYEES, INDIVIDUALLY OR OTHERWISE, HARMLESS FOR ANY AND ALL CLAIMS FOR INJURIES OR DAMAGES.**

In consideration of my participation in and the use of the Studio's facilities, I hereby release and covenant not to sue the Studio, its owners, instructors, employees or contractors from any and all present claims resulting from ordinary negligence and inherent risk of use of the facilities and equipment of the Studio including but not limited to any loss, injury, damage or liability sustained by me while on or about the premises of the Studio.

By signing and dated below, I certify that I understand the foregoing questions and my answers are true and complete. I also understand that if this information changes in any way in the future, it is my responsibility to notify my MAT Specialist, and that I assume the risk for any changes in my medical condition that might affect my ability to exercise.

Before beginning a new fitness program or other significant change in your physical activity levels, you are advised to consult with your physician or primary health care provider. Only a physician or qualified health care provider is able to diagnose and prescribe treatment for specific health conditions.

I acknowledge that I have read the foregoing statements and fully understand the content thereof, and that if I choose not to consult with my physician or primary health care provider, I do so at my own risk.

_____

Signature Date

_____

Please print name

_____

Parent or legal guardian (if participant is under age eighteen) Date