



**CD FIT FITNESS PROGRAM**

**CLASS LOCATION:** \_\_\_\_\_ **START DATE:** \_\_\_\_\_

NAME (Last, First, Middle Initial): \_\_\_\_\_

HOME ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

PHONE (H): \_\_\_\_\_ (W): \_\_\_\_\_

FAX: \_\_\_\_\_ CELL/PAGER: \_\_\_\_\_

EMAIL ADDRESS: \_\_\_\_\_

OCCUPATION AND EMPLOYER: \_\_\_\_\_

DOB: \_\_\_/\_\_\_/\_\_\_ AGE: \_\_\_\_\_ HEIGHT: \_\_\_\_\_ WEIGHT: \_\_\_\_\_ GENDER: \_\_\_\_\_

PHYSICIAN: \_\_\_\_\_ PHONE: \_\_\_\_\_

PERSON TO NOTIFY IN CASE OF EMERGENCY: \_\_\_\_\_

RELATIONSHIP: \_\_\_\_\_ PHONE: \_\_\_\_\_

**Disclosure & Release**

I, \_\_\_\_\_ agree to participate in a physical fitness program with a trainer or trainers of The Clarence Duhart's Fitness Program/CD Fit (the "Program").

I recognize that exercise is not without varying degrees of risk to the musculoskeletal and/or cardio-respiratory systems. I hereby certify that I know of no medical problems (except those of which I have informed the Program) that would increase my risk of illness and injury as a result of participation in a physical fitness program with the Program. \_\_\_\_\_ (INITIALS)

I understand and have been informed that there exists the possibility of adverse changes during the exercise program. I have been informed that these changes could include abnormal blood pressure, fainting, disorders of heart rhythm, stroke, and very rare instances of heart attack or even death. \_\_\_\_\_ (INITIALS)

I agree to waive, release, remise, and discharge the Program and its agents, officers, principles, employees, and affiliates of any and all claims, demands, actions or damages of any kind resulting from participation in the Program. The undersigned further states he/she understands and assumes any and all risks with participation in the Program. \_\_\_\_\_ (INITIALS)

\_\_\_\_\_  
**Participant' Signature**

\_\_\_\_\_  
**Date**



**CD FIT: HIGH PERFORMANCE TRAINING**

NAME (Last, First, Middle Initial): \_\_\_\_\_

**Health History Questionnaire**

1. Please indicate if you have had or currently have any of the following medical conditions:

_____ Heart Disease	_____ Chest Pain	IF YES TO ANY OF THESE, PLEASE EXPLAIN: _____ _____ _____
_____ Anemia	_____ Back Trouble	
_____ Diabetes	_____ Asthma	
_____ Joint Pain	_____ Hernia	
_____ <i>Fainting Spells</i>	_____ <i>Epilepsy</i>	
_____ <i>Bleeding</i>	_____ <i>High Blood Pressure</i>	

2. Please describe any history of hospitalizations, operations and/or serious injuries:

\_\_\_\_\_

\_\_\_\_\_

3. Are you currently taking any medications (including non-prescription)? Please provide specifics (i.e., what type, quantity, etc.)

\_\_\_\_\_

\_\_\_\_\_

4. Please circle Yes or No to the following:

Do you have or have you had any pain or tightness in the front or back of your chest? Yes No

If yes, is it during exertion and/or with anxiety? Yes No

Have you ever been told you have an abnormal EKG? Yes No

*Do you ever have swelling of the feet and/or ankles following long periods of standing or intense physical activity? Yes No*

Does your heart ever beat irregularly? Yes No

Has a physician ever said you have a heart murmur? Yes No

Do you get cramps in the back of your legs when you walk? Yes No

Have you noticed any circulatory problems in your feet or hands? Yes No

Do you have chronic lower back pain? Yes No

Do you have pain in your legs and/or feet? Yes No

Do you have joint pain, stiffness, swelling, or instability? Yes No

Do you have trouble walking/jogging or in using your hips, shoulders or knees? Yes No

\_\_\_\_\_  
**Participant's Signature**

\_\_\_\_\_  
**Date**