Body Structure Medical Fitness
2600 Gribbin Dr
Lexington, KY 40517

Pre-Evaluation Guidelines For Your Comprehensive Evaluation

The Microfit system is a safe, fun and effective way to evaluate your physical fitness level. You will receive a comprehensive personal profile report along with your consultation which will show how you compare with others of your age and sex. We suggest you schedule a follow-up evaluation in 6-8 weeks so you can see a comparative analysis of your progress.

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IN ORDER TO ASSURE THE MOST ACCURATE RESULTS, PLEASE FOLLOW THESE GUIDELINES:

1. It is important that you disclose any health or medical problem you may have prior to your evaluation or during your Health History Review. If you are under a physician's care for heart disease, high blood pressure, back pain or any other serious health problem, you should get clearance from your doctor before participation in this program.

2. Avoid any strenuous exercise within four hours of your evaluation.

3. Avoid eating a heavy meal before your evaluation. A light (low fat) breakfast or lunch up to two hours before is okay.

4. Avoid the use of alcohol, caffeine, tobacco, drugs or medications within four hours of your appointment. Use of any of these substances may significantly distort your cardiovascular results (i.e. heart rate, blood pressure, Vo_2 Max).

5. Dress in athletic attire. We recommend a t-shirt, shorts and athletic shoes. Avoid pants that cannot roll above your thigh because they make it difficult to get an accurate skinfold measurement on the mid-thigh which determines your percent body fat.

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We are confident that our services rendered will help you reach your desired goals. NO MEMBERSHIP/NO CONTRACT is required. We encourage you to make a commitment to the health and fitness lifestyle and to tell your friends about this exciting new program.

BODY STRUCTURE MEDICAL FITNESS FACILITY
www.bodystructure.com

Phone: (859) 268-8190
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Body Structure Clinic

Health History

Name: __________________________ Date of Birth: ___/___/___AGE_____SSN or Drivers Lic#____________

Address: ____
Street City State Zip

Phone: (H)_________________ (W) _______________(C) __________________

Email:________________________

Sex________Height______Weight_______ Are you = right handed_____ left handed_____

In case of emergency, whom may we contact?

Name: ____________________ Relationship: ____________________ Phone: _________________

Personal Physician:

Name:________________________ Phone:_________________________

Address:____

Are you currently taking any medication(s)? Yes or No If yes, what are you taking and for what condition(s):____

____

How were you referred to this program? (Please be specific.)_____________________________________

____

Present History:

Have you ever had, or are currently experiencing, any of the following:

Rheumatic fever	Y	N	****Chest pain/discomfort at rest or with mild exertion/exercise**	Y	N
****Heart attack**	Y	N	****Shortness of breath (unexplained)**	Y	N
****Heart surgery**	Y	N	****Swelling of the feet or ankles**	Y	N
****Disease of any artery**	Y	N	Skipped heart beats	Y	N
Kidney disease	Y	N	Coughing up blood	Y	N
Gout	Y	N	Arthritis/swollen, stiff joints	Y	N
Thyroid disease	Y	N	****Dizziness or fainting**	Y	N
Epilepsy	Y	N	Frequent headaches	Y	N
Depression	Y	N	Frequent colds	Y	N
Asthma	Y	N	Recurrent Sore throat	Y	N
Emphysema	Y	N	Recurrent nose bleeds	Y	N
Chronic Bronchitis	Y	N	Indigestion	Y	N
Liver disease	Y	N	Wheezing spells	Y	N
Vomiting blood	Y	N	****Heart murmur**	Y	N
***Diabetes**	Y	N	****Need to sit up to breathe comfortably**	Y	N
****Rapid Heart Rate**	Y	N			

Family History:

*Have any of your immediate family members (parents, grandparents, or siblings) had or ever had any of the following?

Heart attack	Y	N	Whom:______________________	Age:_________
Heart surgery	Y	N	Whom:______________________	Age:_________
High blood pressure	Y	N	Whom:______________________	Age:_________
Stroke	Y	N	Whom:______________________	Age:_________
Diabetes	Y	N	Whom:______________________	Age:_________
High cholesterol	Y	N	Whom:______________________	Age:_________

**Heart Disease:

Have you ever been told by a physician that you had:

An abnormal EKG Y N

Heart disease Y N

*High Blood Pressure:

Have you ever been told you have high blood pressure? Y N

If yes, did you receive treatment? Y N

What was the treatment and are you still undergoing any treatment?____________________

____

*Cholesterol:

Have you ever been told you have high cholesterol? Y N

If yes, what is your most recent cholesterol level?__________________

*Smoking:

Do you smoke currently? Y N

Have you smoked regularly within the past 6 months? Y N

*Exercise:

Are you currently exercising at least 30 minutes most days of the week? Y N

Has your physician ever advised you against exercise? Y N

Orthopedic:

Do you have any orthopedic (including back) injuries, arthritis, or osteoporosis, which would interfere with your daily activity or ability to exercise? Y N

If yes, please explain:____

____

Are you presently receiving any physical therapy or any form of treatment for any injuries? Y N

If yes, please explain:____

____

Hospitalization:

Have you ever been hospitalized with any illness or injury? Y N

If yes, please explain:____

Pertinent Information:

Is there any pertinent information not already described? Y N

If yes, please explain____

____

Signature: ___________________________________ Date: _________________

Consultant: ___________________________________ Date: __________________

Section I. **(Client use only)**

1. What are your short term and long term personal health goals?
   - Short term (3 months): ____
   - Long term (1 year): ____
2. What are your expectations of the service your personal trainer will provide?

   ____
3. What equipment do you presently have at home?

   ____
4. Would you be willing to perform additional exercise sessions at home? ______________
5. Current nutritional information:
   - number of meals you are eating daily ___________
   - number of snacks you are eating daily __________
   - do you plan your meals daily? Y N
   - number of meals you "eat out" weekly _________
   - number of fast food meals weekly __________ and at a restaurant ___________
   - are your meals balanced including fat, carbohydrates, and protein? Y N
   - If no, what foods does your diet consist of?

     ____

Section II. **(Administration use only)**

1. Contraindications to be aware of (*note the Health History and any information provided by the client):

2. Evaluators recommendations for general programming:

3. Projected starting date: ___________________________. Number of sessions per week: ________. ½ or hour session: ______.

4. What days will the client train? _________________________. Male or Female trainer? ________.

5. Choice of times: 1st __________________. 2nd ________________. 3rd ___________________.

CONSENT / RELEASE FOR PARTICIPATION & INFORMATION

Purpose and Explanation of Procedures

I, ________________________, hereby consent to voluntarily engage in a personal fitness training program ("Program") with Body Structure. The Program may include stress management as well as health/fitness education activities. The levels of exercise I perform will be based upon my cardio respiratory (heart and lungs) and muscular fitness. I acknowledge it has been recommended to me by Body Structure that I be examined by a physician of my choice and obtain his/her approval for my participation in the program within (30) days of the date set forth below. I understand that I am expected to follow the trainer's instructions with regard to my exercise and health and fitness related programs. If I am taking prescribed medications, I have already so informed Body Structure and further agree to so inform my trainer promptly of any changes which may doctor or I have made with regard to use of any medications or change in my medical status. I will be given the opportunity for periodic assessment & evaluation at regular intervals after the start of my Program.
I have been informed that during my participation in the above described Program, I will be asked to complete the physical activities unless symptoms such as fatigue, shortness of breath, chest discomfort appear. At this point, I have been advised that it is my right to decrease or stop exercise and that it is my obligation to inform the trainer of my symptoms.
I understand that during the performance of exercise, the trainer will periodically monitor my performance which may include: measuring my pulse or blood pressure or assessing my feelings of exertion for the purposes of monitoring my progress. I understand that during the performance of the Program, physical touching and positioning of my body by the trainer may be necessary to assess my muscular and bodily reactions to specific exercises as well as ensure that I am using proper technique and body alignment. I
expressly consent to the physical contact for the stated reasons above.
I, ____________________, hereby consent to the release of my information to medical professionals.

Risks: It is my understanding and I have been informed that there exists the possibility during exercise of adverse changes including, but not limited to, abnormal blood pressure, fainting, physical dizziness, disorders of heart rhythm. I further understand and have been informed that there exists the risk of bodily injury. I have been advised that appropriate efforts will be made to minimize these occurrences by proper assessments of my condition before each session, trainer supervision during exercise and by my own control of exercise efforts. I fully understand the risks associated with exercise, including the risk of bodily injury, heart attack, stroke or even death, and knowing these risks, it is my desire to participate as herein indicated

Inquiries and Freedom of Consent: I have been given the opportunity to ask questions regarding the procedures of the Program and I have received satisfactory answers to those questions.
Generally these requests which have been noted by Body Structure's staff and their responses are:

I agree that Body Structure shall not be liable or responsible for any injuries to me resulting from my participation in the Program (whether at home or in studio): and I expressly release and discharge Body Structure, its owners, employees, agents, and/or administrators or assigns from any claims, suits, and the like of as a result of any injury or damage which may occur in connection with my participation in the Program, excepting only an injury caused by the gross negligence or intentional act of such person or persons. This Release shall be binding upon my heirs, executors, administrators and assigns. I have read this form and understand all of its terms. I consent to the rendition of all services and procedures as herein by the Body Structure staff.

____________________________	____________________________
Participant Signature	Body Structure Staff Signature
____________________________	____________________________
Print Name	Print Name
____________________________	____________________________
Date	Date

Medical Clearance Request Form

Physician: ______________________________

Date: ________________
Fax No: _____________ Phone No:_______________

Patients Name: _______________________________

Birth Date: ________________
Daytime Phone No: _________________

Your patient requested to participate in the following programs at Body Structure

- ❑ Resistance training program supervised by certified personal trainer. ***(Individually designed program on resistance training, cardiovascular exercise, & nutritional counseling, with emphasis on lifestyle modification, using ACSM guidelines)***

- ❑ Post Rehabilitation Program supervised by certified personal trainer. ***(Co-operative management between Physical Therapist and trainer on resistance training, cardiovascular exercise, & nutritional counseling using ACSM guidelines)***

Due to client's medical history, (attached/not attached) it is necessary that we request a medical clearance. Contraindications from health history are as follows:

____

____

____

____

Physician Exercise Recommendations:

_______ No Restrictions

Recommendations:

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Physician Signature: ______________________________ Date________________