

HEALTH HISTORY AND CURRENT CONDITIONS

Have you ever participated in physical therapy? Yes No If yes, please provide reason for therapy, approximate date of therapy, and results:

Do you have any areas of weakness, muscle tension, muscle tightness, or constant stiffness? Yes No If yes, please describe:

Are you, or do you currently have, any of the following?

- | | | |
|---|---|---|
| <input type="checkbox"/> Severe Injury / Swelling | <input type="checkbox"/> Pregnant | <input type="checkbox"/> Acute Joint Pain |
| <input type="checkbox"/> Acute Illness, Fever, Chills, or Infection | <input type="checkbox"/> Acute Flare-up of Chronic Disease (MS, RA) | <input type="checkbox"/> Migraine Headache |
| <input type="checkbox"/> Left-side Chest Pain or Left Arm Pain | <input type="checkbox"/> Severe Fatigue/Severe Depression | <input type="checkbox"/> Loss of Sensation in Arms, Legs, or Pelvis |
| <input type="checkbox"/> Shortness of Breath/Tightness in Chest | <input type="checkbox"/> Unexplained Weight Loss | <input type="checkbox"/> Resting Blood Pressure > 160/100 |
| <input type="checkbox"/> Radiating Arm or Leg Pain | <input type="checkbox"/> Loss of Bladder or Bowel Control | <input type="checkbox"/> Worsening Pain or Intense Pain at Night |

Do you currently have, or have you ever had, any of the following?

- | | | |
|---|---|---|
| <input type="checkbox"/> Anemia/Dizziness/Fainting | <input type="checkbox"/> Depression | <input type="checkbox"/> Multiple Sclerosis (MS) |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Neck Pain, Tension or Fatigue |
| <input type="checkbox"/> Allergies/Sinus/Asthma | <input type="checkbox"/> Heart Condition | <input type="checkbox"/> Osteoporosis/Osteopenia |
| <input type="checkbox"/> Carpal Tunnel Syndrome | <input type="checkbox"/> Headaches | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Hernia | <input type="checkbox"/> Spinal Injury (neck and/or back) |
| <input type="checkbox"/> Chronic Fatigue Syndrome | <input type="checkbox"/> Hypoglycemia (low blood sugar) | <input type="checkbox"/> Tendonitis |
| <input type="checkbox"/> COPD (Respiratory Disease) | <input type="checkbox"/> Hypertension (high blood pressure) | <input type="checkbox"/> Thyroid Condition |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> IBS / Crohn's | <input type="checkbox"/> Surgeries _____ |

Do you have joint injuries/pain (shoulders, elbows, wrists, hips, knees, ankles)? Yes No If yes, please describe: _____

Are you currently under any restriction(s) by your doctor for any reason? Yes No If yes, please describe: _____

Please list any other injuries, illnesses, or health conditions we should consider when customizing your workout plan: _____

INFORMED CONSENT

I have agreed to participate in a workout program consisting of physical activity, including but not limited to, body conditioning machinery used during the workout sessions at SuperSlow Zone. I affirm that I am in good physical condition and do not suffer from any disability that would contribute to an injury.

INITIALS: _____

LIABILITY WAIVER

Participating in an exercise program naturally involves risk of injury, whether you or someone else causes it. For and in consideration of the design of an exercise program for the client by SuperSlow Zone, the client agrees:

I certify that my responses to the Client Fitness Goals and Background questions are true and complete to the best of my knowledge; and that any exercise program shall be undertaken at my sole risk; and I release my instructor from all claims, injuries, damages, action or causes of action, and in consideration of my participation in any SuperSlow Zone workshops and workout sessions; I release SuperSlow Zone, its affiliates, subsidiaries, directors, officers, employees, agents and franchisees from any claims, liability, demands, and causes of action arising from my participation in an exercise program and from all acts of negligence on the part of the company, facility, its owners, agents or employees.

I fully understand that I may injure myself as a result of my participation, and I release SuperSlow Zone from any liability now or in the future, including but not limited to, heart attack, stroke, muscle strain, muscle pull or tear, shin splints, heat exhaustion, knee or foot injuries, back injuries and any other illness, soreness or injury occurring during or after my participation in an introductory workout and/or an exercise program.

CLIENT'S SIGNATURE

DATE (Month/Day/Year)

EXERCISE CONSIDERATIONS

Please read and initial each of the following considerations to help us assure your safety and success while participating in a SuperSlow Zone strength training program. Your instructor will often remind you of these considerations to optimize every workout and make every workout as safe and productive as possible.

PLEASE DO NOT EXERCISE WITH GUM, CANDY, OR ANY LOOSE OBJECT IN YOUR MOUTH

Never have anything loose in your mouth; you could inhale the object and cause a medical emergency. Initials _____

BREATHE CONTINUOUSLY

Never hold your breath or let pressure build up behind your closed airway during exercise.
Do not blow, hiss, gasp, grunt or make guttural sounds. Initials _____

BE WARY OF EXERCISE-INDUCED HEADACHE (EIH)

Watch out for a dull pain or increased pressure in the back of your neck or head, or behind one of your eyes.
If you feel or suspect an oncoming EIH, safely lower the weights and stop the exercise immediately. Tell your instructor.
Never try to resume your workout if EIH has not completely subsided. Initials _____

MAINTAIN PROPER HEAD & NECK POSITION

Keep your chin a fist-distance from your chest.
Do not turn your head side-to-side or look up or down.
Keep your head still and your neck relaxed and in a neutral position. Initials _____

DON'T EXPECT THE "ULTIMATE" WORKOUT

Your instructor needs time to assess appropriate resistance and machine settings.
You need time to learn and practice the SuperSlow Zone exercise protocol. Initials _____

MUSCLE SORENESS FOLLOWING YOUR WORKOUT

Do not correlate a good or productive workout with soreness. You will always have a productive workout at SuperSlow Zone, but you will not always be sore.
Adverse levels of soreness can usually be relieved by working out again the next day.
Call us to arrange a complimentary "relief session". Initials _____

GO SLOWLY FOR SAFETY

You will lift the weights in ten (10) seconds and lower the weights in ten (10) seconds, never unloading the musculature.
Slow and deliberate movement only throughout each repetition results in the safest method of exercise. No yanking, jerking, heaving, lunging, or explosive movement. Initials _____

APPOINTMENT CONSIDERATIONS

WE RESPECT YOUR TIME

We will start on time. If an instructor is not available for you within ten (10) minutes of your appointment start time, you will receive a free session.
Twenty-four (24) hour advance notice for cancellations is required to avoid forfeiture of session.
Always call to reschedule your appointment as soon as possible. We will do our best to accommodate last-minute schedule changes.
If we do not hear from and you miss an appointment for any reason, we will attempt to contact to you. Initials _____