



Confidential
MetrixStrength™ Client Information Form

Name _____ Birth Date ____ / ____ / ____

Address _____

City _____ ST _____ Zip _____

Phone: Home: _____ Work: _____ Cell: _____

E-mail: _____

Emergency Contact: _____ Relationship: _____
First number to call: _____ Circle type: Cell Home Work
Second number to call: _____ Circle type: Cell Home Work

How did you hear about MetrixStrength?

- | | | |
|------------------------------------|--|--|
| <input type="checkbox"/> Friend | <input type="checkbox"/> Spouse/Partner | <input type="checkbox"/> Physician: Name _____ |
| <input type="checkbox"/> Newspaper | <input type="checkbox"/> Mailer/Circular | <input type="checkbox"/> TV |
| <input type="checkbox"/> Radio | <input type="checkbox"/> Print Ad | <input type="checkbox"/> Internet |
| <input type="checkbox"/> Drive-By | <input type="checkbox"/> Other: _____ | |

Goals and Expectations (check all that apply):

- | | | |
|---|--|--|
| <input type="checkbox"/> Lose Weight | <input type="checkbox"/> Gain Weight | <input type="checkbox"/> Reduce body fat |
| <input type="checkbox"/> Improve tone/shape | <input type="checkbox"/> Increase strength | <input type="checkbox"/> Improve cardio |
| <input type="checkbox"/> Increase metabolism | <input type="checkbox"/> Prevent injuries | <input type="checkbox"/> Increase bone density |
| <input type="checkbox"/> Increase muscle mass | <input type="checkbox"/> Other: _____ | |

Your Physician(s): name, city, phone number (if known; seen in past 3 yrs)

- Primary Care _____
- Orthopaedic? _____
- Podiatrist? _____
- Other? _____

Physical Activity (check/list all that apply):

Past 3 yrs	Currently	Activity	Weekly Frequency
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Continued on Reverse

MetrixStrength™ Client Information Form (Cont'd)

Please circle Yes or No to indicate your response. If any are answered Yes, please provide explanation:

1. Y N Do you have any heart problems?
2. Y N Do you have high or low blood pressure?
3. Y N Have you had any/do you have any chronic illnesses?
4. Y N Do you have diabetes?
5. Y N Are you subject to dizziness, lightheadedness, or fainting spells?
6. Y N Do you experience frequent headaches?
7. Y N Do you have a hernia of any kind?
8. Y N Have you had lymph nodes removed?
9. Y N Have you had any recent surgeries?
10. Y N Do you have any implants or medical appliances?
11. Y N Are you taking any medications?
12. Y N Do you have any limited range of motion?
13. Y N Do you have or had you ever had any joint problems—knee, shoulder, elbow, wrist, etc.?
14. Y N Do you have or have you ever had any back or neck problems?
15. Y N Have you been diagnosed with arthritis?
16. Y N Have you ever dieted to lose weight?
17. Y N Do you know of any reason why your physician would not want you to undertake a strength training program like MetrixStrength?

Explanation (list question number):

Assumption of Risk, Release, and Indemnity

The use of MetrixStrength facilities involves the risk of injury. The undersigned agrees that he/she fully understands and voluntarily accepts this risk and agrees that Metrix Illinois (dba Metrix Physical Therapy & Fitness) will not be held liable for any injury, with or without limitation personal, bodily, or mental injury, economic loss or damage to the undersigned. If there arises any claim by anyone based on any injury, loss, or damage described herein, which involves the undersigned and any other individual also bound by this Agreement, the undersigned agrees to (a) defend Metrix Illinois against such claims and (b) indemnify Metrix Illinois for all obligations resulting from such claims.

Waiver of Liability

The undersigned understands that there is an inherent risk of injury in the use of Metrix Illinois' strength training facility. The undersigned agrees to assume all risk of injury, whether physical or mental, for the undersigned, any other individual bound by this Agreement while such persons are using the Company's strength training facilities and equipment. The undersigned hereby waives any and all claims or actions that may arise against Metrix Illinois, its owners, directors, employees or contractors as a result of any such injury to any such person. Such risks include but are not limited to (a) use of any of the Company's equipment, (b) injuries or medical disorders arising from activity at the Company's facility, including but not limited to heart attacks, strokes, heart stress, sprains, broken bones, torn or damaged muscles or ligaments, (c) injuries resulting from actions taken or decisions made regarding medical or survival procedures while on Company premises.

Client Certification

I certify that all information provided on this form is true, complete, and accurate. I attest to having had a medical examination within the past twelve months that verified that I am in good health and am able to participate in a strenuous fitness program like MetrixStrength. I agree, without reservation, to the Assumption of Risk, Release, and Indemnity and Waiver of Liability statements above. I also certify that I have read the following forms, and that I have added my initials to indicate that I understand and have completed the forms:

Client Policies Sheet_____, Client Pricing & Credit Card Form_____

Signature: _____

Date: _____

Witness: _____

Date: _____

Accepted- Metrix Illinois: _____

Date: _____