



(408) 209-9695

CLIENT-TRAINER CONTRACT

I, the undersigned, do agree to the following:

- I, the client, agree to give 24 hours notice for cancellation of sessions. I understand that if 24 hours notice is not given, the fee for that session will stand.
- I, the trainer, agree to give 24 hours notice for cancellation of sessions. I understand that if 24 hours notice is not given, the fee for that session will be waived.
- I, the trainer, agree that upon cancellation of a session, by trainer, a make-up session will be made available to the client.
- I, the client understand that if I receive credit for a missed session, the credit must be used within 60 days of the missed session, or it will be waived.
- I, the client, understand that if I am not on time for a session(s), the session(s) may be cut short and the full fee applied.
- I, the trainer, understand that if I am not on time for sessions, the time will be made up at that session or a subsequent session.

- I, the client, understand that after purchasing a training package, no refunds will be given to the client for any reason. All sales are final.
- I, the client, understand that the outcome of any fitness program will be due to the work that the participants do, what the participants' abilities are, and their genetic makeup. The factors outside of the personal training sessions are beyond the control of the trainer.
- I, the client, agree that the trainer can terminate a particular exercise or workout at any time if the trainer believes I am not in suitable condition for exercise—for example, if I, the client, am noticeably under the influence of drugs or alcohol, disclose the fact that I have abused drugs or alcohol medications or if I have not eaten anything in reasonable amount of time pre-workout, etc.

Client Signature Date

Guardian's Signature (if under 18) Date

Personal Trainer Date

LAMORTELIFT.COM / ASHLEY LAMORTE / LAMORTELIFT@GMAIL.COM

Health & Fitness Liability Waiver / Informed Consent Form

“I, _____, have enrolled in the personalized health and fitness programs offered by “LaMorte Lift” and Ashley LaMorte. I recognize that the program may involve strenuous physical activity including, but not limited to, muscle strength and endurance training, cardiovascular conditioning and training, and other various fitness activities. I hereby affirm that I am in good physical condition and do not suffer from any known disability or condition which would prevent or limit my participation in this exercise program. I acknowledge that my enrollment and subsequent participation in purely voluntary and in no way mandated by “LaMorte Lift” and Ashley LaMorte.

“In consideration of my participation in this program, I hereby release “LaMorte Lift” and its agents from any claims, demands, and causes of action as a result of my voluntary participation and enrollment.”

“ I fully understand that I may injure myself as a result of my enrollment and subsequent participation in this program and I hereby release “LaMorte Lift” and its agents from any liability now or in the future for conditions that I may obtain. These conditions may include, but are not limited to, heart attacks, muscle strains, muscle pulls, muscle tears, broken bones, shin splints, heat prostration, injuries to knees, injuries to back, injuries to foot, or any other illness or soreness that I may incur, including death.”

I HEREBY AFFIRM THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE STATEMENTS.

(Participant Signature) _____

(Date) _____

Email _____

Phone _____

LAMORTE LIFT INFORMED CONSENT

I, _____, give my consent to participate in the physical fitness program conducted by LaMorte Lift.

Benefits: Participation in a regular program of physical activity has been shown to produce positive changes in a number of organ systems. These changes include increased work capacity, improved cardiovascular efficiency, and increased muscular strength, flexibility, power and endurance..

Risks: I recognize that exercise carries some risk to the musculoskeletal system (sprains, strains) and the cardio respiratory system (dizziness, discomfort in breathing, heart attack). I hereby certify that I know of no medical problem (except those noted below) that would increase my risk of illness and injury as a result of participation in a regular exercise program..

Testing and Evaluation Results: I understand that I will undergo initial testing to determine my current physical fitness status. The testing will consist of completing this health inventory, having cardiovascular fitness evaluated, and being tested for muscular fitness and body composition.

I further understand that such screening is intended to provide Alameda Personal Training with essential information used in the development of individual fitness programs. I understand that my individual results will be made available only to me. I also understand that the testing is not intended to replace any other medical test or the services of my physician. I will be provided a copy of all test results.

I may share the results with whomever I please, including my personal physician. By signing this consent form I understand that I am personally responsible for my actions during my tenure with LaMorte Lift and that I waive the responsibility of my training if I should incur any injury as a result of my negligence.

Signed: _____ Date: _____

HEALTH HISTORY QUESTIONNAIRE

Answer each question by printing the necessary information. Your answers are confidential.

PERSONAL INFORMATION:

Name: _____
Date of Birth: _____ Age: _____
Address: _____
City, State, Zip: _____
Home Phone: _____
Work Phone: _____
Employer: _____ Occupation: _____
In case of emergency, please notify:
Name: _____ Relationship: _____
Address: _____
City, State, Zip: _____
Home Phone: _____
Work Phone: _____

MEDICAL INFORMATION:

Physician: _____
Phone: _____
Are you under the care of a physician, chiropractor, or other? Yes No
health care professional for any reason?
If yes, list reason: _____

Are you taking any medications? Yes No
(if yes, complete the following)
Type Dosage/Frequency Reason for taking

Please list any allergies: _____

1. Has your doctor ever said your blood pressure was too high? YES NO
2. Has your doctor ever told you that you have a bone or joint problem that has been or could be made worse by exercise? YES NO
3. Are you over age 65? YES NO
4. Are you unaccustomed to vigorous exercise? YES NO
5. Is there any reason not mentioned here why you should not follow a regular exercise program? YES NO
If so, please explain. _____
6. Have you recently experienced any chest pain associated with either exercise or stress? YES NO
If so, please explain. _____

SMOKING:

Please check the box that best describes your current habits:

Non-user or former user; Date quit: _____

Cigar and/or pipe

15 or less cigarettes per day

16 to 25 cigarettes per day

26 to 35 cigarettes per day More than 35 cigarettes per day

FAMILY & PERSONAL MEDICAL HISTORY:

If there is a family history for any condition, please enter "family" on the line. If you are personally experiencing any of these conditions, fill the information in on the line.

Asthma: _____

Respiratory/Pulmonary Conditions _____

Diabetes: Type I: _____ Type II: _____ How long? _____

Epilepsy: Petite Mal: _____ Grand Mal _____ Other: _____

Osteoporosis: _____

LIFESTYLE AND DIETARY FACTORS:

Occupation Stress Level: Low / Medium / High

Energy Level: Low / Medium / High

Caffeine Intake/Daily: _____ Alcohol Intake/Weekly: _____

Colds per Year: _____ Anemia: _____

Gastrointestinal Disorder: _____

Hypoglycemia: _____

Thyroid Disorder: _____

Pre/Postnatal: _____

Cardiovascular: _____

High Blood Pressure: _____ Hypertension: _____

High Cholesterol: _____

Hyperlipidemia: _____

Heart Disease: _____

Heart Attack: _____ Stroke: _____

Angina _____ Gout: _____

MUSCULOSKELETAL INFORMATION:

Please describe any past or current musculoskeletal conditions you have incurred such as muscle pulls, sprains, fractures, surgery, back pain, or general discomfort:

Head / Neck: _____

Upper Back: _____

Shoulder / Clavicle: _____

Arm / Elbow: _____

Wrist / Hand: _____

Lower Back: _____

Hip / Pelvis: _____

Thigh / Knee: _____

Arthritis: _____

Hernia: _____

Surgeries: _____

Other: _____

NUTRITIONAL INFORMATION:

Are you on any specific food / nutritional plan at this time? Yes No

If yes, please list: _____

Do you take dietary supplements? Yes No

If yes, please list: _____

Do you experience any frequent weight fluctuations? Yes No

Have you experienced a recent weight gain or loss? Yes No

If yes, list change: _____

Over how long? _____

How many beverages do you consume per day that contain caffeine? _____

How would you describe your current nutritional habits? _____

Other food/nutrition issues you want to include (food allergies, mealtimes, etc.)?

EXERCISE HABITS:

Please check next to the statement that best describes your work and exercise habits:

Intense occupational and recreational exertion Moderate occupational and recreational exertion

Sedentary work and intense recreational exertion Sedentary work and moderate recreational

exertion Sedentary work and light recreational exertion Complete lack of all exertion

To what degree do you perceive your environment as stressful? Work: Minimal Moderate

Average Extremely

Home: Minimal Moderate Average Extremely

Do you work more than 40 hours a week? _____

Please make any other comments you feel are pertinent to your exercise program.

Signature of Client Date

SCREENING QUESTIONNAIRE:

1. Has a doctor ever said you have heart trouble? Yes No
2. Have you ever had angina pectoris, sharp pain, or heavy pressure in your chest as a result of exercise, walking, or other physical activity such as climbing stairs (Note: this does not include the normal out of breath feeling that results from normal activity.)? Yes No
3. Do you experience any sharp pain or extreme tightness in your chest when you are hit with a cold blast of air? Yes No
4. Have you ever experienced rapid heart action or palpitations? Yes No
5. Have you ever had a real or suspected heart attack, coronary occlusion, myocardial infarction, coronary insufficiency, or thrombosis? Yes No
6. Have you ever had rheumatic fever? Yes No
7. Do you have diabetes, hypertension or high blood pressure? Yes No
8. Does anyone in your family have diabetes, hypertension or high blood pressure? Yes No
9. Has more than one blood relative (parent, sibling, first cousin) had a heart attack or coronary artery disease before the age of 60? Yes No
10. Have you ever taken any medication to lower your blood pressure? Yes No
11. Have you ever taken medications or been on a special diet to lower your cholesterol? Yes No
12. Have you ever taken digitalis, quinine, or any other drug for your heart? Yes No
13. Have you ever taken nitroglycerine or any other tablets for chest pain - tablets you take by placing under the tongue? Yes No
14. Are you overweight? Yes No
15. Are you under a lot of stress? Yes No
16. Do you drink excessively? Yes No
17. Do you smoke cigarettes? Yes No
18. Do you have a physical condition, impairment or disability, including a joint or muscle problem, that should be considered before you undertake an exercise program? Yes No
19. Are you more than 65 years old? Yes No
20. Are you more than 35 years old? Yes No
21. Do you exercise fewer than three times per week? Yes No

EXERCISE HISTORY QUESTIONNAIRE:

Name: _____

Are you currently involved in a regular exercise program? Yes No

Do you regularly walk or run 1 or more miles continuously? Yes No

If yes, what is the average of miles you cover in a workout? _____

What is your average minutes per mile? _____

Do you practice weightlifting or calisthenics? Yes No

Are you involved in an aerobic program? Yes No

If yes, what type(s)? _____

What activities would you prefer in a regular exercise program for yourself? Walking and/or running Bicycling(outdoors)

Swimming Stationary running

Stationary biking Tennis

Jumping rope Handball

Basketball Squash Other: _____

Comments: _____
