



t. 604.392-0892  
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w. www.ascendfitneslifestyle.com

## Client Information Questionnaire

Name:

Date of Birth:

Address:

Phone Number:

Alternate Phone:

Email Address:

Occupation:

Emergency Contact Name:

Emergency Contact Number:

Family Doctor:

Family Doctor Number:

### PHYSICAL ACTIVITY READINESS QUESTIONNAIRE:

PAR-Q #1: Has your doctor ever said that you have a heart condition and that you should only do physical activity recommended by a doctor? Yes / No

PAR Q #2: Do you feel pain in your chest when you do physical activity? Yes / No

PAR Q#3: In the past month, have you had chest pain when you were not doing physical activity? Yes / No

PAR Q #4: Do you lose your balance because of dizziness or do you ever lose consciousness? Yes / No

PAR Q #5: Do you have a bone or joint problem (for example, back, knee, or hip) that could be made worse by a change in your physical activity? Yes / No

PAR Q #6: Is your doctor currently prescribing drugs (for example, water pills) for your blood pressure or heart condition? Yes / No

PAR Q #7: Do you know of any other reason why you should not do physical activity? Yes / No

If you answered YES to any question on the PAR-Q, please elaborate below:



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**Personal Medical History:**

**Please check if you have or have ever had any of the following:**

- |  |   |
|--|---|
| <input type="checkbox"/> Heart attack                              | <input type="checkbox"/> Low blood pressure   |
| <input type="checkbox"/> Fainting spells                           | <input type="checkbox"/> High blood cholesterol   |
| <input type="checkbox"/> Dizziness/ light headedness               | <input type="checkbox"/> High blood pressure  |
| <input type="checkbox"/> Concussion                                | <input type="checkbox"/> Eye problems   |
| <input type="checkbox"/> Cancer                                    | <input type="checkbox"/> Thyroid problems   |
| <input type="checkbox"/> Type 2 diabetes                           | <input type="checkbox"/> Vascular diseases  |
| <input type="checkbox"/> Stroke                                    | <input type="checkbox"/> Mood disorder such as depression/ anxiety                                |
| <input type="checkbox"/> Recent hospitalization                    | <input type="checkbox"/> Motor Vehicle Accident   |
| <input type="checkbox"/> Orthopedic problems or arthritis          | <input type="checkbox"/> Severe Menstrual Cramps  |
| <input type="checkbox"/> Hernia                                    | <input type="checkbox"/> Pelvic floor issues or incontinence                                      |
| <input type="checkbox"/> Neck/Back Pain                            | <input type="checkbox"/> Diastasis Recti (separation of abdominals)                               |
| <input type="checkbox"/> Severe stress                             | <input type="checkbox"/> Food, drug or environmental allergies                                    |
| <input type="checkbox"/> Cancer                                    | <input type="checkbox"/> Known hormonal imbalance   |
| <input type="checkbox"/> Chronic bruising                          | <input type="checkbox"/> Chronic headaches  |
| <input type="checkbox"/> Chronic cold or flu                       | <input type="checkbox"/> Eating disorder  |
| <input type="checkbox"/> Sprains/ strains                          | <input type="checkbox"/> Surgeries  |
| <input type="checkbox"/> Joint injury / pain (including back pain) | <input type="checkbox"/> Pregnant in the last year/planning on becoming pregnant in the next year |
| <input type="checkbox"/> Tingling/ Numbness                        |   |

**If you answered yes to any of the above, please explain:**

**Medications:**

Are you currently taking any medications or supplements? Yes / No

**If yes, please list the what are you are taking and what they are being used for:**

**Please list current injuries/ aches & pains:**



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**HEALTH CARE COMMUNICATION RELEASE**

I authorize Ascend Fitness Inc. to communicate with my health care team regarding my fitness program and any relevant medical information or health concerns.

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*Client Name (print)*

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*Signature*

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*Date*



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## **INFORMED CONSENT, WAIVER AND RELEASE AGREEMENT**

**IMPORTANT: THIS IS A LEGAL DOCUMENT. PLEASE IT READ CAREFULLY. BY SIGNING THIS DOCUMENT YOU WILL WAIVE CERTAIN LEGAL RIGHTS, INCLUDING THE RIGHT TO SUE.**

I acknowledge that I have voluntarily chosen to participate in the group fitness activities offered by Ascend Fitness Inc. I understand the possible strenuous nature of the activities and in particular, I understand that strength, flexibility and aerobic exercise, including the use of exercise equipment, is a potentially hazardous activity with certain risks, some of which include but are not limited to, abnormal blood pressure; muscle or joint soreness; soft tissue injuries; broken bones, back, neck knee and foot injuries; fainting; heart attack; and/or death. I understand that I can refuse participation in any activity at any time, or chose to stop an activity at any time. I understand that this exercise program does not provide any form of medical treatment. I hereby certify that I am fit to participate in any and all such fitness activities. I acknowledge and represent that I have either had a physical examination and been given my physician's permission to participate in exercise activity and use equipment, or that I have decided to participate in exercise activity and use equipment without the approval of my physician and do hereby assume all responsibility of any nature and kind whatsoever for my participation and activities and utilization of equipment in the exercise activities. If I am under a doctor's care for diabetes, hypertension, heart disease, seizures, arthritis, recent injury or surgery, or if I am pregnant, or if there are other possible prohibitions to exercise, I represent that I have consulted my doctor before commencing this exercise activity. To promote the safety of my participation, and the other participant's, in the exercise activities I will report any unusual symptoms I may experience during exercise to Ascend Fitness Inc. Such symptoms may include, but are not limited to, joint pain, irregular heart rhythm, dizziness, tightness or pressure in my chest, and shortness of breath. I understand that I may feel some muscle soreness or discomfort after some of the exercises. I am aware that the scheduling or content of training workout may be changed on occasion due to circumstances beyond the control of staff. I understand that registration payments are non-refundable. Payment for class is required upon registration. There will be a \$25 NSF fee charged in the event of a returned cheque. I have had the opportunity to ask questions or seek independent legal advice with respect to this document. Having read and understood this Informed Consent, Waiver, and Release Agreement, I assume all risks for my health and well being and hold Ascend Fitness Inc., it's fitness coaches, employees and staff, or any persons involved with this program or testing procedures harmless from any liability. I agree that Ascend Fitness Inc., it's fitness coaches, staff, and employees, shall not be liable for any direct, indirect, general, special, incidental or consequential damages whatsoever, whether such damages arise in contract, negligence, tort, under statute, in equity, at law, or otherwise, including, but not limited to, damages incurred for personal injury, harm or death, suffered by me that arise out of, or are in any way related to my participation in the exercise activities offered by Ascend Fitness Inc.. I, for myself, my heirs, executors, administrators and assigns or anyone else who may claim on my behalf, hereby release and forever discharge Ascend Fitness Inc., it's fitness coaches, staff, and employees, from any and all liability for any loss, damage, injury, harm or expense that I may suffer as a result of participating in the exercise activities offered by Ascend Fitness Inc. due to any cause whatsoever. I understand and agree that if any portion of this document is severed or rendered inoperable, the liability of the Ascend Fitness Inc., it's fitness coaches, staff, and employees shall in no circumstances exceed the amount paid by me for the services rendered, or if no amount was paid directly by the me, five dollars (\$5.00) CAD. I understand and agree that this informed consent, waiver and release, agreement applies to all exercise activities offered by Ascend Fitness Inc. that I participate in, whether occurring at present or in the future.

Signed: \_\_\_\_\_

Name: \_\_\_\_\_ Date: \_\_\_\_\_