



**EMPOWERED**  
PERSONAL TRAINING STUDIO  
*Class Member Information Sheet*

Name (First/MI/Last): \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Telephone: Cell \_\_\_\_\_ Work or Home: \_\_\_\_\_

E mail: \_\_\_\_\_ ~~XXXXXXXXXX~~ How did you hear about us? \_\_\_\_\_

Birth date:  ~~XX~~ Age: \_\_\_\_\_ Sex: M F Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Physician's name: \_\_\_\_\_ Telephone: \_\_\_\_\_

Date of last physical exam:   Allergies (including medications): \_\_\_\_\_

Emergency contact: \_\_\_\_\_

Telephone: \_\_\_\_\_ Relationship to client: \_\_\_\_\_

*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
2. Do you feel pain in your chest when you are doing physical activity? Yes No
3. Do you feel pain in your chest when you are not doing physical activity? Yes No
4. Do you lose your balance because of dizziness? Yes No
5. Do you ever lose consciousness? Yes No
6. Is your doctor currently prescribing drugs (for example, water pills) for your blood pressure or heart condition? Yes No
7. Do you have a bone or joint problem that could be made worse by a change in physical activity?  
Yes No
8. Do you know any reason why you should not do physical activity? Yes No
9. If you are 65 years of age or older, are you unaccustomed to vigorous exercise?  
Yes No NA

*If you answered yes to any of the questions, please explain on back of paper and it is our strongest recommendation that you get doctors clearance before starting the program.*