POWER2BFIT

Health History Questionnaire

Name _____ DOB _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell _____

Email Address _____

Emergency Contact (Name and Number) _____

Please circle either yes or no whether you have had or currently have any of the following conditions:

Heart Disease	Yes	No	Diabetes	Yes	No
Heart Attack	Yes	No	Asthma	Yes	No
Chest Pain	Yes	No	Shortness of Breath	Yes	No
High Blood Pressure	Yes	No	Bone and/or Joint Problems	Yes	No
Other Heart Related Conditions	Yes	No	Low Back Pain	Yes	No
Fainting or Dizzy Spells	Yes	No	Arthritis	Yes	No
Stroke	Yes	No	Migraine/History of Headaches	Yes	No
Epilepsy/Seizures	Yes	No			

If you answered yes to any of the above items, please explain each condition below:

Do these conditions; restrict you from your exercise program? Yes No

When were you diagnosed with cancer?

Type of cancer:

What stage of cancer?

What type of surgery was performed and when?

What type of radiation and when?

What type of chemotherapy and when?

Current status:

What medications are you currently taking (cancer related and non-cancer related)? Please list the name of the medication and the condition that you are taking it for below:

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HEALTH HISTORY QUESTIONNAIRE

Name: **Date:** :

	Yes	No
Have you had any other surgeries (non-cancer related) that would affect your exercise program? Yes No If yes, for what conditions and when?		

	Yes	No
Have you consulted your physician about increasing your physical activity and/or having a fitness evaluation? Yes No If yes, did your physician state any restrictions? If so, please list below.		

	Yes	No
Do you smoke? Yes No If yes, how many per week? If you previously smoked, how long ago did you quit?		

When did you first start thinking about starting a regular exercise program?

Are you currently involved in any cardiovascular activity? Yes No If yes, please state below, what type and how often:

How would you rate your activity level during the day on a scale from 1 to 5?

Very Inactive 1 2 3 4 5 **Very Active**

	Yes	No
Do you ever get tired or fatigued during the day? Yes No If yes, what specific time of day?		

On average how many hours of uninterrupted sleep do you get each night per week?

On the scale below, how do you feel about your night's rest (non-interrupted sleep)?

No Rest 1 2 3 4 5 **Full Rest**

Please answer the following questions regarding your sleep quality:

I am satisfied with the quality and length of my sleep. Yes No

I snore, wake up gasping/stop breathing. Yes No

I don't sleep well because of pain. Yes No

I don't get restful sleep, but it is NOT interfering with my daytime functioning/performance. Yes No

I use non-prescription medication/supplements because I have trouble sleeping. Yes No

How many times a day do you usually eat?

Please rate the importance of your health and fitness on a scale from 1 to 5.

Low Priority 1 2 3 4 5 **High Priority**

Please state the goals you would like to achieve through a personal wellness program:

Power2bfit.com pam@power2bfit.com (703) 395-2643

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Liability Waiver

I am voluntarily participating in an exercise program provided by Power2bfit, LLC. I will be receiving instruction and information concerning fitness and wellness techniques, which may include weight training and other physical activities. I represent and warrant that I have no physical or mental health condition that would prevent my safe participation in this exercise program. I agree that if I am pregnant, or have a known cardiac arrhythmia (including very slow heart rate), a history of heart block, or if I am taking antipsychotic medications that may result in an adverse reaction in connection with physical activities, I will consult with and obtain the permission of a physician prior to engaging in any weight training or other physical activities in connection with this exercise program.

I am willingly and voluntarily assuming any risks, injuries or damages including but not limited to: death, fainting, disorders in heartbeat, serious neck and spinal injuries that may result in complete or partial paralysis or brain damage, serious injury to virtually all bones, joints, ligaments, muscles, tendons, and other aspects of the musculoskeletal system, and serious injury or impairment to other aspects of my body, general health, and well being, which I might incur as a result of participating in this exercise program, and agree that _____ will not have any liability for such injuries or damages, to the maximum extent allowed by applicable law.

I will provide equipment to be used with connection to workouts. Examples include, a chair, dumbbells, and resistance bands, to name a few. In addition, Power2bfit, LLC, has not inspected my equipment and has no knowledge of its condition. I understand that I take sole responsibility for my equipment.

I acknowledge and agree that _____ is not a medical professional and does not provide any medical diagnoses or treatments. I agree that if I have any medical condition, I will seek the help of a medical professional.

Although Power2bfit, LLC will take precautions to ensure my safety, I expressly assume and accept sole responsibility for my safety and for any and all injuries that may occur. In consideration of the acceptance of this entry, I, for myself and for my executors, administrators, and assigns, waive and release any and all claims against Power2bfit, LLC and any of their staffs, officers, officials, volunteers, sponsors, agents, representatives, successors, or assigns and agree to hold them harmless from any claims or losses, including but not limited to claims for negligence for any injuries or expenses that I may occur while exercising. These exculpatory clauses are intended to apply to any and all activities occurring during the time for which I have contracted with Power2bfit, LLC.

I expressly waive all rights afforded by any statute which limits the effect of a release with respect to unknown claims, and I represent and warrant I am signing this agreement freely and willfully and not under fraud or duress.

HAVING READ THE ABOVE TERMS AND INTENDING TO BE LEGALLY BOUND HEREBY AND UNDERSTANDING THIS DOCUMENT TO BE A COMPLETE WAIVER AND DISCLAIMER IN FAVOR OF POWER2BFIT, LLC, I HEREBY AFFIX MY SIGNATURE HERETO.

Client's Name (please print clearly) _____

Date: _____

Client's Signature _____

Client's Address _____

Date: _____

Parent/Guardian Signature (if applicable) _____

Date: _____
Representative from Power2bfit, LLC Signature _____

Power2bfit.com pam@power2bfit.com (703) 395-2643

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Authorization to Disclose Protected Health Information

Primary account holder information

Last name	First name		M.I.
Street address	City	State	ZIP
Email address (required)	Daytime phone ( )	SSN or ID number	

HIPAA authorization (to be completed by dependent)

My protected health information is individually identifiable health information, including demographic information collected from me or created or received by a health care provider, a health plan, my employer, or a health care clearinghouse, and relates to: (i) my past, present, or future physical or mental health condition; (ii) the provision of the health care to me; or (iii) the past, present or future payment for the provision of health care to me.

In accordance with the provisions of the Health Insurance Portability and Accountability Act (HIPAA), I, the undersigned, grant permission to the recipient to disclose protected health information (as defined in HIPAA) to the following person or persons:

_____

Purpose of authorization: ☐ At my request ☐ Family member assisting with health care ☐ Other: _____

Any limitations that I impose on the recipient with respect to this authorization are declared below:

_____

_____

_____

This authorization will remain in effect for the duration of the state expiration requirement (may vary from 24-48 months) based off of primary account holder's state of residency. In addition, I may revoke this authorization at any time by notifying the recipient.

If at any time you need to alter this authorization form, please contact the recipient.

Authorization of HIPAA disclosure (to be completed by dependent)

I understand that by granting this authorization, the person who obtains this information may disclose it to other individuals with or without my consent and in so doing, the information would no longer be protected under HIPAA. I understand that my authorizing the use and disclosure of my information is not a condition of enrollment in this health plan, eligibility for benefits or payment of claims.

Dependent's name (please print)	Date
Dependent's signature	Dependent's date of birth (mm/dd/yyyy)

Note: If the person signing above is a personal representative of the named individual, attach copy of document granting authority to the personal representative.

☐ An Insurance Documentation Fee of $25 will be charged if documents are needed to be released.