Consent Waiver

I, _____, herby voluntarily give consent to engage in a fitness test and a physical activity program. I understand that the cardiovascular fitness test will involve progressive stage of increased effort and that at any time I may terminate the test and activity for any reason. I understand that during some tests I may be encouraged to work at maximal effort and that at any time I may terminate the test or activity for any reason.

I understand that there are certain changes that may occur during the exercise test. They include abnormal blood pressure, fainting, disorders of heart beat and very rare instances of a heart attack. I understand that every effort will be made to minimize problems by preliminary examination and observation during the testing.

I understand that I am responsible for monitoring my own condition throughout the testing, and should any unusual symptoms occur I will cease my own participation and inform the test administrator of the symptoms. Unusual symptoms include, but are not limited to: chest discomfort, nausea, difficulty breathing, and joint or muscle injury.

Also in consideration of being allowed to participate in the fitness tests, I agree to assume all risks of such fitness testing and hereby release and hold harmless the trainer who performs these tests and their agents and employees from any and all health claims, suits, losses or causes of action for damages, for injury or death, including claims for negligence, arising out of or related to my participation in the fitness assessment or fitness program.

I have read the foregoing carefully and I understand my consent. I have been advised to consult my physician before starting any physical activity program. Any questions which may have occurred to me concerning the informed consent have been answered to my satisfaction.

Client_____ Witness_____

Date_____ Date_____

BodyEvolver PT PRO

Client: _____

Date: _____

❑ Yes ❑ No	Has your doctor ever told you that you have heart trouble?
❑ Yes ❑ No	Do you currently have diabetes?
❑ Yes ❑ No	Are you male 40 years or older, or female 50 years or older?
❑ Yes ❑ No	Have you are you had pains in your heart or chest?
❑ Yes ❑ No	Do you at times feel faint, or have spells of severe dizziness?
❑ Yes ❑ No	Do you have asthma, emphysema or bronchitis?
❑ Yes ❑ No	Do you currently have thyroid problems?
❑ Yes ❑ No	Have you had any of the following: Shortness of breath especially upon exertion; heart palpitations; leg cramps during walking; or persistent swelling around the ankles?
❑ Yes ❑ No	Has a doctor ever told you about bone or joint problems such as arthritis that has been aggravated by exercise or might be made worse by exercise?
❑ Yes ❑ No	Are you pregnant?
❑ Yes ❑ No	Has a doctor ever told you that your blood pressure was too high?
❑ Yes ❑ No	Have your parents, brothers, or sisters suffered from heart disease before the age of 55?
❑ Yes ❑ No	Are you currently a cigarette smoker or have you smoked within the last six months?
❑ Yes ❑ No	Has your doctor told you that your cholesterol level is too high?

BodyEvolver PT PRO

_____ plans to engage in a scientifically based health, fitness and nutrition program designed to support optimal health. An aerobic exercise and resistance training program will be designed base on a submaximal exercise test (not medically supervised).

Please complete the sections below and return this form to your patient.

Thank you.

The American College of Sports Medicine recommends a graded exercise test prior to engaging in an exercise program for the following reasons:

- People with two or more cardiac risk factors.
- People exhibiting signs or symptoms suggestive of cardio pulmonary or metabolic diseases.
- People with documented heart diseases.

❑ Patient cleared to exercise with no restrictions.

❑ Patient cleared to exercise with the following restrictions.

❑ Patient NOT cleared to exercise due to.

I have ❑ have not ❑ provided a current blood lipid and glucose profile.

Patient diagnosis (if any): _____

Medications that may affect participation:_____

Comments: _____

Send periodic progress reports Yes ❑ No ❑

Physician

Signature: _____ Date: _____

Physician Name: _____

Address: _____

City: _____ State: _____ Zip:_____ Phone: ( ) _____

E-Mail: _____

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Self-Reported or diagnosed cardiovascular disease, diabetes or risk factors. A graded exercise test (GXT) is requested (mark one of the following):

❑ Results of a current GXT (12 months or less) enclosed with recommendations.

❑ I Recommend the patient undergo a Graded Exercise Test (GXT).

❑ Patient clear to exercise with the following guidelines.

- Training heart rate: _____BPM. Blood Pressure Not to exceed _____/_____mmHg
- Frequency _____times/week for _____minutes of (continuous / discontinuous exercise).
- Strength training: Yes/No Limits:_____
- Other: _____

❑ Patient cleared to exercise with the following restrictions.

❑ Patient NOT cleared to exercise due to.

I have ❑ have not ❑ provided a current blood lipid and glucose profile.

Patient diagnosis (if any): _____

Medications that may affect participation:_____

Comments: _____

Send periodic progress reports Yes ❑ No ❑

Physician

Signature: _____ Date: _____

Physician Name: _____

Address: _____

City: _____ State: _____ Zip:_____ Phone: ( ) _____

E-Mail: _____