



# WELLSPRING THERAPY, INC.

*The source for healing*

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Date \_\_\_\_\_

Have you ever been a client at Wellspring Therapy? Y N

*Fecha*

Whom may we thank for referring you? \_\_\_\_\_

*¿A quién agradeceríamos por la referencia?*

Legal Name (Last, First, Middle) \_\_\_\_\_

*Nombre Legal (Apellido, Primer Nombre)*

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

*Dirección (No P.O. Box) Ciudad Estado Zip*

Home Phone (\_\_\_\_) \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_ Date of Birth \_\_\_\_\_ Sex M F

*Teléfono Teléfono celular Fecha de Nacimiento Sexo M F*

Social Security Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Driver's License # \_\_\_\_\_

*Seguro Social Numero de Licencia*

E-mail Address: \_\_\_\_\_ Occupation: \_\_\_\_\_

In case of emergency who should be notified? \_\_\_\_\_ Phone Number (\_\_\_\_) \_\_\_\_\_

*En caso de emergencia a quién notificamos Teléfono*

**All forms must be filled out and signed prior to the start of the first personal training session/orientation.**

**Consent for Care:** I hereby give my consent to the staff of Wellspring Fitness to provide services and to exercise professional judgment regarding any additional care and services that may be necessary. In signing this agreement, I acknowledge that I have voluntarily chosen to participate in a program of progressive physical exercise which can enhance the musculoskeletal and cardio respiratory systems with a Certified Personal Trainer. **I hereby affirm that I am in good physical condition and do not suffer from any disability that would limit or prevent my participation in this exercise program.** I understand that I, the client, am fully responsible for any injury before, during, or after workouts. The trainer will not be held accountable in any manner, legal or otherwise. I understand that workout sessions may occur at Wellspring's facility, in public parks or public places and that the owner of those properties will not be held accountable for any injury occurring before, during or after a workout session. Focusing during your workout and following directions will help prevent any injury. It is my responsibility to communicate any symptoms or discomfort during the session. I understand that I am expected and encouraged to ask any questions I may have regarding my treatment. I acknowledge that I have been informed of the possible strenuous nature of the program and the potential for unusual, but possible, physiological results including, but not limited to, muscle strains, sprains, soreness, abnormal blood pressure, fainting, disturbances of heart rhythm, heart attack or death. Every effort will be made to minimize these risks. By signing this document I also acknowledge that I have been informed of the need to obtain a physician's examination and approval prior to beginning this exercise program.

I, the undersigned, waive and release and agree to hold harmless and indemnify Wellspring Fitness, Wellspring Therapy Inc., local civic governments, employees/contractors, agents, officers, and directors against any and all claims, demands, and causes of action any way connected with my participation in the exercise program now or in the future. This agreement is binding upon my heirs, executors, administrators and assigns.

**Appointment/Compliance:** Arrive for your appointment **on time**. If you are late, you may not get your full appointment, but will be billed for the time scheduled for you. **Sign in** at the front desk when you arrive. We request a 24-hour **cancellation notice** of a scheduled appointment so that we may offer that time to another patient. Failure to do so will result in a \$50.00 fee due and payable at the following visit.

**Confidentiality:** All client information will be treated as privileged and confidential and will not be revealed to any person (other than the fitness staff involved in the client's exercise program) without expressed written consent. Obtained information, however, may be used for statistical or scientific purposes with right to privacy retained.

**All fees including payment for services and cancellation fees are non-refundable.**

**Please sign below, indicating that you have read the above and understand and agree to the terms set forth.** By your signature, you further agree to final and binding arbitration for any and all claims, disputes or controversies arising between you and Wellspring Therapy Inc., whether contractual, statutory or common law. You additionally agree to waive your rights to a jury trial and to utilize the services of, and to arbitrate under the then rules promulgated by, the American Arbitration Association.

\_\_\_\_\_  
Signature of Client or Legal Guardian for Participants under the age of 18

Date \_\_\_\_\_



### Health Questionnaire & Goal Assessment

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

**Have you ever had or do you currently have:**

Chest Pain	Y	N	Asthma	Y	N
Angina	Y	N	Seizures	Y	N
Pacemaker	Y	N	Diabetes	Y	N
High Blood Pressure	Y	N	Cancer	Y	N
High Cholesterol	Y	N	Arthritis	Y	N
Stroke	Y	N	Headaches/dizziness	Y	N
Short of Breath	Y	N	Hypo/hyperthyroidism	Y	N
Currently Pregnant	Y	N	Anxiety/Panic Attacks	Y	N
			Depression	Y	N

Any major surgeries? If yes, please give details:

\_\_\_\_\_

Any major muscular injuries: If, yes, please give details

\_\_\_\_\_

Are you currently taking any medications: Please list any medications below:

Med: \_\_\_\_\_ Used for: \_\_\_\_\_

Med: \_\_\_\_\_ Used for: \_\_\_\_\_

Med: \_\_\_\_\_ Used for: \_\_\_\_\_

Doctor's Name: \_\_\_\_\_ Doctor's Phone: \_\_\_\_\_

Do you smoke? \_\_\_\_\_ If yes. How much? \_\_\_\_\_

Do you drink? \_\_\_\_\_ If yes. How much? \_\_\_\_\_

Do you drink caffeine? \_\_\_\_\_ If yes, How much? \_\_\_\_\_

Have you had a baby within the past two years?: \_\_\_\_\_

\*Date of baby's birth: \_\_\_\_\_ Normal delivery: Y N

Do you have any other conditions or limitations witch may affect your fitness program: Y N If yes: explain:

\_\_\_\_\_

Client Signature: \_\_\_\_\_ Date \_\_\_\_\_

**Current Fitness History** (activities you perform): \_\_\_\_\_

\_\_\_\_\_

Have you worked with a Personal Trainer before? Y N \_\_\_\_\_

**Ultimate Fitness Goals:**

\_\_\_\_\_ **To increase overall fitness level**  
\_\_\_\_\_ **To increase cardiovascular fitness**  
\_\_\_\_\_ **To increase strength**  
\_\_\_\_\_ **To increase flexibility**  
\_\_\_\_\_ **To lost weight**  
\_\_\_\_\_ **Other:** \_\_\_\_\_

1) Do you want to lose weight: Y N. If yes how many pounds?: \_\_\_\_\_

2) How long have you attempted to lose this weight?: \_\_\_\_\_

3) What methods have you tried? \_\_\_\_\_

4) How would like to feel? \_\_\_\_\_

Trainer's Notes:

\_\_\_\_\_

\_\_\_\_\_

**Therapist Recommendations for Fitness Program:**