Peach,Body & Soul Fitness
Personal Training Agreement
Packet 2023

Personal Training Agreement

By signing this Agreement, I am agreeing to the following terms of Peach, Body & Soul Fitness dba PB&S Fitness:

- Full payment for all sessions must be made prior to scheduling appointement. If on a payment plan, I will provide payment on my scheduled payment dates.

- I will be charged for a cancelled appointment unless I notify PB&S Fitness of cancellation at least 24 hours prior to the scheduled time. If I am more than 15 minutes late for my appointment, I agree that the lost time will be forfeited, but I will be charged for that session unless I request.
- I understand that PB&S Fitness will try to accommodate preferences for certain appointment times and specific trainer requests, but cannot guarantee availability due to other appointments, scheduling conflicts, and other factors.
- I understand that the staff and/or instructor will not be held responsible for any injuries, illnesses, or expenses from my participation, especially if I have neglected to disclose a known medical condition or similar information about myself that might affect my ability to participate.
- In signing below, I agree to the above conditions as well as other policies of the facility. I also acknowledge that I have received and understand the Consent and Release form from PB&S Fitness,.

Signature	Printed Name
Address	(H) Phone Number
City, State, Zip	(W) Phone Number
Email Address	Birthdate
Staff/Trainer	Date

* The fee for the program is payable in advance and, except as provided below, is nonrefundable even if the client cannot or does not participate in all of the training sessions in the program. As an exception, if as a result of a physical injury or adverse health condition, the client is unable to complete the program, then a portion of the fee will be refunded on the following basis: (1) 30% of the fee will be non-refundable and will compensate Peach, Body & Soul Fitness for administrative and related expenses.

The client must make a written request of the refund, specifying in that request the personal injury or health condition preventing her/his participation in the program. Each refund will be paid within thirty days after Peach, Body & Soul Fitness received that written request.

Consent and Release

** Please read the following carefully. **

In connection with my enrollment in the exercise program and/or the use of the equipment and facilities of PB&S Fitness, I have read this document and understand it is a release of all claims. If I am engaging a personal trainer, I have read and understand the terms of the Personal Training Agreement.

I have been informed and acknowledge that PB&S Fitness, makes no claims as to medical results, which can or may be obtained through participation in this program, the use of the facilities and/or equipment.

I understand that PB&S Fitness will not be responsible for suggesting nor providing any medical treatment to participants. Participants should rely only upon advice given by a licensed professional or their own physician and not by any unlicensed employee, agent or contractor of PB&S Fitness. I consent to the administration of any immediate resuscitation measures deemed advisable by my trainer or other qualified personnel.

I represent that I have either (a) been given my physician's permission to participate in fitness activity, or (b) decided to voluntarily participate in the program and have accepted voluntarily all risks related to the program without the approval of my physician. I represent that I am not aware of any medical or physical condition that would prevent me from participating in this program or from using equipment or facilities or would involve a serious health risk to me. **I have informed, and agree to keep informed fully, PB&S Fitness of any physical medical condition or disability that would prevent or jeopardize my participation in this program or the use of equipment and facility.**

I have been advised and understand that participation in the program and use of the equipment and facility presents some unavoidable risk of injury, especially to people who have preexisting injuries, illness or medical disabilities. I recognize that participation may cause short-term aggravation of some symptoms, feelings of tiredness, lightheadedness, increased energy, mood changes and other effects. **I understand that I should stop exercising immediately if I detect any pain, dizziness or discomfort during the program**.I agree to abide by all rules of PB&S Fitness and agree to follow explicitly all instructions given during the course of my instruction.

In consideration of being allowed to participate in the program or use the facilities and equipment, I (on behalf of my family, estate, heirs, or assigns) hereby waive, release, forever discharge and agree not to sue PB&S Fitness, its directors, shareholders, employees, instructors, contractors and members from any and all claims, demands, damages, and causes of action, present or future, whether known or unknown, arising from my participation in this program or the use of the equipment or facilities, excepting only those claims, actions or damages directly caused by the willful or intentional acts of PB&S Fitness. I affirm that I am of legal age or am a parent or adult guardian representing a minor and freely signing this agreement.

I voluntarily sign my name evidencing my acceptance of these provisions.

Signature	Date

Printed Name

Health History Questionnaire

Please answer the following questions to the best of your ability. For the following questions, unless otherwise indicated, circle the single best choice for each question. As is customary, all of your responses are completely confidential and may only be used in group summaries and/or reports. All information collected is subject to the Privacy Act of 1974. **If you have any physical handicaps or limitations which would require special assistance with this questionnaire, please let your trainer know.** This form is in accordance with the American College of Sports Medicine guidelines for risk stratification when followed correctly by your trainer. Your trainer should be certified with a national organization in order to use these forms correctly.

Name:	Ht:	Wt:	If bloodwork is available. For use by staff only:
Gender:	Age:	Birthdate:	TCH:
Address:			HDL:
City:	State:	Zip:	LDL:
Home Phone:	Work Phone:		Trig.:
Cell Phone:	Email:		Glu.:
Emergency Contact:		Phone:	BP:
Personal Physician:		Phone:	

1.	Have you ever had a definite or suspected heart attack or stroke?	Yes	No
2.	Have you ever had coronary bypass surgery or any other type of heart surgery?	Yes	No
3.	Do you have any other cardiovascular or pulmonary (lung) disease (*other than* asthma, allergies, or mitral valve prolapse)?	Yes	No
4.	Have you ever had a history of diabetes, thyroid, kidney, or liver disease? (Please circle which one(s).)	Yes	No
5.	Have you ever been told by a health professional that you have had an abnormal resting or exercise (treadmill) electrocardiogram (EKG)?	Yes	No
6.	If you answered Yes to any of Questions 1 through 5, please describe:		

7. Do you currently have any of the following:

a.	pain or discomfort in the chest or surrounding areas that occurs when you engage in physical activity	Yes	No
b.	shortness of breath	Yes	No
c.	unexplained dizziness or fainting	Yes	No
d.	difficulty breathing at night except in upright position	Yes	No
e.	swelling of the ankles (recurrent and unrelated to injury)	Yes	No
f.	heart palpitations (irregularity or racing of the heart on more than one occasion)	Yes	No
g.	pain in the legs that causes you to stop walking (claudication)	Yes	No
h.	known heart murmur	Yes	No
•	Have you discussed any of the above with your personal physician?	Yes	No

8. Are you pregnant or is it likely that you could be pregnant at this time? Yes No

9. Have you had surgery or been diagnosed with any disease in the past three months? (If yes, please list date and surgery/disease.) Yes No

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10. Within the past 12 months has a health professional told you that your blood cholesterol or lipids profile was abnormal? Yes No

11. Do you currently smoke cigarettes or have you quit within the past 12 months? Yes No

12. Have your father or brother(s) had heart disease prior to age 55 *or* mother or sister(s) had heart disease prior to age 65? Yes No

13. Within the past 12 months, has a health professional told you that you have high blood pressure (systolic ≥ 140 *or* diastolic ≥ 90)? Yes No

14. Currently, do you have high blood pressure or within the past 12 months, have you taken any medicines to control your blood pressure? Yes No

15. Have you ever been told by a health professional that you have a fasting blood glucose greater than or equal to 140 mg/dl? Yes No

16. Describe your regular physical activity or exercise program:

    1. type:
    2. frequency (days per week):
    3. duration (minutes):
    4. intensity (low, moderate, high):
    5. additional information: _____

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17. If you answered Yes to any of Questions 7 through 16, please describe:

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18. Are you currently under any treatment for any blood clots?	Yes	No
19. Do you have problems with bones, joints, or muscles that may be aggravated with exercise?	Yes	No
20. Do you have any back/neck problems?	Yes	No
21. Have you been told by a health professional that you should not exercise?	Yes	No
22. Are you currently being treated for any other medical condition by a physician?	Yes	No
23. Are there any other conditions (mitral valve prolapse, epilepsy, history of rheumatic fever, asthma, cancer, anemia, hepatitis, etc.) that my *hinder* your ability to exercise?	Yes	No
24. During the past six months have you experienced any *unexplained* weight loss or gain (greater than ten pounds for no known reason)?	Yes	No

25. If you answered Yes to any of Questions 18 through 24, please describe

_____

_____

26. Please list below all prescription and over-the-counter medications you are currently taking:

Medicine:	Reason for taking:	Dosage:	Amount/Frequency:

27. Are there any medicines that your physician has prescribed to you in the past 12 months which you are currently not taking? (If yes, please list.)	Yes	No

_____

I have answered the HHQ questions accurately and completely. I understand that my medical history is a very important factor in the development of my fitness/wellness program. I understand that certain medical or physical conditions which are known to me, but which I do not disclose to my trainer may result in serious injury to me. If any of the above conditions change, I will immediately inform my trainer of those changes. I, knowingly and willingly, assume all risks of injury resulting from my failure to disclose accurate, complete, and updated information in accordance with the attached questionnaire. I also understand that in order to properly risk stratify my HHQ, my trainer should have a minimum of a national certification as a personal trainer. My trainer also verbally explained this statement to me to my understanding.

Client's Signature: Date:

Trainer's Signature: Date:

Training Dates (please specify)

Days of the Week **Time-Window (1 hour intervals)**

Monday

Tuesday

Wednesday

Thursday

Friday

Saturday
(7-8 am $15 Booty Camp) (5-6am unavailable)

Sunday
(7-8am $15 Booty Camp)(5-6am unavailable)

(7-8 am blocked)

What is the frequency? Please circle

3 days a week 4 days a week 5 days a week

Monthly? Yes No

Client Signature:

Date: