GLADIATOR FITNESS
ELITE OUTDOOR BOOT CAMP

VISITOR'S ENLISTMENT INFORMATION
AND HEALTH HISTORY QUESTIONNAIRE

NAME (Last, First, Middle Initial): ____

HOME ADDRESS: ____

CITY: __________________________________ STATE: _______ ZIP CODE:_________

PHONE: _____________________ EMAIL ADDRESS: ____________________________

EMPLOYER: ____

DOB: _____/_____/_____ AGE:_________ HEIGHT:_________ WEIGHT:_________

GENDER:___

PHYSICIAN: __________________________ PHONE:____________________________

PERSON TO NOTIFY IN CASE OF EMERGENCY: ________________________________

RELATIONSHIP: _______________________ PHONE: ____________________________

Disclosure & Release

I, ________________________ agree to participate in a physical fitness program with a trainer of Gladiator Fitness.

I recognize that exercise is not without varying degrees of risk to the musculoskeletal and/or cardiorespiratory systems. I hereby certify that I know of no medical problems (except those of which I have informed the Program) that would increase my risk of illness and injury as a result of participation in a physical fitness program with the Program. _______ (Initials)

I understand and have been informed that there exists the possibility of adverse changes during the exercise program. I have been informed that these changes could include abnormal blood pressure, fainting, disorders of heart rhythm, stroke, and very rare instances of heart attack or even death. _______ (Initials)

I agree to waive, release, remise, and discharge the Program and its agents, officers, principles, employees of any and all claims, demands, actions or damages of any kind resulting from participation in the Program. The undersigned further states he/she understands and assumes any and all risks with participation in the Program. _______ (Initials)

________________________________ ________________ ____________
Participant Date Witness

www.gladiatorfitness.net

Health History Questionnaire

1. Please indicate if you have had or currently have any of the following medical conditions:

___Heart Disease	___Chest Pain	IF YES TO ANY OF THESE, PLEASE EXPLAIN
___Anemia	___Back Trouble	______________________________
___Diabetes	___Asthma	______________________________
___Joint Pain	___Hernia	______________________________
___Fainting Spells	___Epilepsy	______________________________
___Bleeding	___High Blood Pressure	

2. Please describe any history of hospitalizations, operations and/or serious injuries:

____
____
____
____

3. Are you currently taking any medications (including non-prescription)? Please provide specifics (i.e., what type, quantity, etc.)

____
____
____
____

4. Please circle Yes or No to the following:

Do you have or have you had any pain or tightness in the front or back of your chest? Yes No

If yes, is it during exertion and/or with anxiety? Yes No

Have you ever been told you have an abnormal EKG? Yes No

Do you ever have swelling of the feet and/or ankles following long periods of standing or intense physical activity? Yes No

Does your heart ever beat irregularly? Yes No

Has a physician ever said you have a heart murmur? Yes No

Do you get cramps in the back of your legs when you walk? Yes No

Have you noticed any circulatory problems in your feet or hands? Yes No

Do you have chronic lower back pain? Yes No

Do you have pain in your legs and/or feet? Yes No

Do you have joint pain, stiffness, swelling, or instability? Yes No

Do you have trouble walking/jogging or in using your hips, shoulders or knees? Yes No