

Client information contained within this form is considered strictly confidential. Your honest responses allow us to better understand your current and past health issues, and ensure the delivery of the most appropriate training program

Name:		Parent / Guardian:	
Address:	City:	State:	Zip:
Phone:	Email:		
Date of Birth:	Sex: Male Female	Instagram:	
Occupation / Sports(s):		School:	

How did you hear about PerformFit (Check all that apply)

<input type="checkbox"/> Friend / Teammate (Name): _____	<input type="checkbox"/> Internet	<input type="checkbox"/> Facebook
<input type="checkbox"/> Coach (Name): _____	<input type="checkbox"/> Email	<input type="checkbox"/> Instagram
<input type="checkbox"/> Event (Name): _____	<input type="checkbox"/> Radio / TV	<input type="checkbox"/> Print Ad

May we contact this person to thank them? Yes No

Contact Information:

Email:	Phone:
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Medical History

Do you have, or have you ever had, any of the following injuries/conditions? If so, please check all that apply and state the year in which the injury occurred.

<input type="checkbox"/> Concussion(s) _____	<input type="checkbox"/> Neck Injury _____	<input type="checkbox"/> Shoulder Injury _____	<input type="checkbox"/> Elbow Injury _____
<input type="checkbox"/> Arm/Wrist/Hand _____	<input type="checkbox"/> Back Injury _____	<input type="checkbox"/> Arthritis _____	<input type="checkbox"/> Hip Injury _____
<input type="checkbox"/> Knee Injury _____	<input type="checkbox"/> Leg Injury _____	<input type="checkbox"/> Ankle Injury _____	<input type="checkbox"/> Foot Injury _____
<input type="checkbox"/> Muscle Strain _____	<input type="checkbox"/> Tendon Injury _____	<input type="checkbox"/> Other Injury _____	

Chronic Illness or Condition: Please check those that apply and list year of diagnosis.

<input type="checkbox"/> Frequent Headaches _____	<input type="checkbox"/> Heart Irregularity _____	<input type="checkbox"/> High Blood Pressure _____
<input type="checkbox"/> Stroke _____	<input type="checkbox"/> Seizures _____	<input type="checkbox"/> Diabetes _____
<input type="checkbox"/> Cancer _____	<input type="checkbox"/> Dizziness/Lightheadedness _____	<input type="checkbox"/> Chest Pain w/ Activity _____
<input type="checkbox"/> Shortness of Breath _____	<input type="checkbox"/> Allergies (Please List): _____	<input type="checkbox"/> Surgery (If so, what): _____
<input type="checkbox"/> Asthma (Inhaler Required): ___ Yes ___ No	<input type="checkbox"/> Anything Not Mentioned: _____	

If you answered "yes" to any of the above questions, please consult your doctor before beginning our PerformFit exercise programs.

Name: _____

Date: _____

Damage to Facilities

The participant and/or the responsible party agree to pay for any damage the participant may cause to the facility or other PerformFit property.

Waiver and Release

I acknowledge and agree that by signing this document, I declare that I have no known medical problems that would preclude my participation in the program and in the information provided to PerformFit regarding my medical history and physical condition is, to the best of my knowledge, true and correct. My participation in the PerformFit program is voluntary and I assume all risk of injury or contraction of any illness, virus, or medical condition that may result, or the aggravation of a pre-existing medical condition I may have, or any damage, loss or theft of any personal property resulting or arising out of my participation in the program. I understand and acknowledge that PerformFit has no expertise in diagnosing, examining, or treating any medical condition, whether existing or incurred as a result of my participation in the PerformFit program. I understand and acknowledge that PerformFit has made no guarantee of success or improvement as a result of my participation in the program.

I hereby, on behalf of myself, personal representatives, heirs, executors, administrators, agents and assigns, forever release and discharge PerformFit and its affiliates and their respective affiliates, employees, agents, representatives, successors, and assigns from any and all claims or causes of action (known or unknown) that I may now have or will have in the future arising out of or related to my enrollment in the program or the services provided to me. This waiver and release of liability includes, but is not limited to injuries that result from (a) use of any exercise equipment or facilities provided by PerformFit, (b) use of any exercise equipment or facilities which may malfunction, and (c) any injuries which occur because of slipping and falling while on PerformFit premises or equipment.

I HAVE CAREFULLY READ THIS WAIVER AND RELEASE AND FULLY UNDERSTAND THAT IT IS A COMPLETE RELEASE OF LIABILITY, THAT I HEREBY WAIVE ANY RIGHT THAT I MAY NOW HAVE OR WILL HAVE TO BRING ANY LEGAL ACTION AGAINST PerformFit ITS EMPLOYEES, AGENTS, SUCCESSORS, OR ASSIGNS, FOR ANY LIABILITIES THAT MAY RESULT, WHETHER DIRECTLY OR INDIRECTLY, FROM PerformFit NEGLIGENCE.

Miscellaneous

The provisions in this document are severable and if any provision is determined to be illegal or unenforceable, the remaining provisions and any partially enforceable provisions shall nevertheless be enforceable unless otherwise prohibited by the laws of the State of Maryland. PerformFit's failure to enforce any remedy or provision of the document shall not be construed as a waiver of such remedy or provision.

Cancellation Policy

- a) All membership cancellation requests must be submitted and received thirty (30) days prior to your credit/debit card processing date. All plans and monthly memberships require a minimum of 30 days notice prior to next billing date to assure cancellation of automatic payments. Cancellation requests submitted within the 30 day billing cycle will result in a final payment drawn from your account on your established auto draft date. Once final payment has been drawn from your account, clients will have 30 days from the last bill date to use the facilities. There will be no refund issued once a payment has been charged to your credit card.
- b) There is no refund once the program has started unless an injury or a medical doctor excused illness.
- c) **Cancellation of sessions during the program must be made with at least 24 hours notification. Failure to do so will result in a forfeiture of those sessions.**

Name: _____

Date: _____