

**re:fit**910 Waukegan Road
Glenview, IL 60025(p) 847.657.0881
(f) 847.657.0882

Fitness Client Information:

Your answers to the questions below will help us to design a program which is safe and can be effectively implemented into your lifestyle. If at anytime you are uncomfortable providing answers to any of the questions, please skip that question and proceed to the next one.

Date: _____

Name: _____

Address _____

City _____ **State** _____ **Zip** _____

Phone: (PLEASE CHECK THE PREFERRED NUMBER FOR MESSAGES)

_____ HOME

_____ WORK

_____ CELL

Email: _____

Occupation: _____

Date of Birth: _____ **Gender Identity:** _____

How did you hear about re:fit?

CLIENT/FRIEND (NAME) _____

INTERNET SITE (PLEASE SPECIFY) _____

OTHER _____

How did you hear about Pilates/Gyrotonic®/Feldenkrais™?

NEWSPAPER (PLEASE SPECIFY) _____

MAGAZINE (PLEASE SPECIFY) _____

CLIENT/FRIEND (NAME) _____

INTERNET SITE (PLEASE SPECIFY) _____

OTHER _____

How long has it been since your last thorough medical exam?

WITHIN THE LAST YEAR

1-2 YEARS

3-5 YEARS

6-9 YEARS

OVER 10 YEARS



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Please indicate your smoking habits:

- DO NOT SMOKE/HAVE NEVER SMOKED
- HAVE STOPPED SMOKING
- SMOKE _____ CIGARETTES A DAY

Mark those health conditions that apply to you, either now or in the past. Only those conditions that may be associated with lifestyle are included.

- | | |
|---|--|
| <input type="radio"/> ALLERGY | <input type="radio"/> ANEMIA |
| <input type="radio"/> ARTHRITIS | <input type="radio"/> ASTHMA |
| <input type="radio"/> BOWEL POLYPS | <input type="radio"/> BRONCHITIS OR EMPHYSEMA |
| <input type="radio"/> CANCER | <input type="radio"/> CIRRHOSIS OR LIVER DISEASE |
| <input type="radio"/> DIZZINESS | <input type="radio"/> DIABETES |
| <input type="radio"/> EXPOSURE TO TB | <input type="radio"/> FALLS |
| <input type="radio"/> HEART DISEASE | <input type="radio"/> HIGH BLOOD PRESSURE |
| <input type="radio"/> JOINT OR BONE PROBLEMS (SPECIFY): _____ | |
| _____ | |
| _____ | |

- | | |
|---|--|
| <input type="radio"/> LUNG DISEASE | <input type="radio"/> NERVOUS BREAKDOWN |
| <input type="radio"/> PACEMAKERS/DELIBERATORS | <input type="radio"/> PREGNANCY: PLEASE SPECIFY THE YEAR |

#OF NATURAL BIRTHS _____ #OF CESAREAN BIRTHS _____

- | | |
|--|--------------------------------|
| <input type="radio"/> UNEXPLAINED RAPID GAIN OR LOSS OF WEIGHT | <input type="radio"/> SEIZURES |
| <input type="radio"/> STROKE | <input type="radio"/> ULCERS |
| <input type="radio"/> SURGERY (SPECIFY) _____ | |
| _____ | |
| _____ | |

OTHER SERIOUS HEALTH PROBLEMS (SPECIFY) _____

I consider my present physical condition to be:

- | | |
|------------------------------------|----------------------------|
| <input type="radio"/> EXCELLENT | <input type="radio"/> GOOD |
| <input type="radio"/> FAIR/AVERAGE | <input type="radio"/> POOR |



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How many days have you been in the hospital as a patient in the last 12 months?

Reason for hospitalization?

What did you expect to gain form this program?

- NORMALIZE BODY WEIGHT
- FILL OUT SPECIFIC AREAS
- IMPROVE POSTURE
- INCREASE DRIVE AND ENDURANCE
- IMPROVE SUPPLENESS AND FLEXIBILITY
- IMPROVE METABOLISM
- IMPROVE GLANDULAR AND ORGAN FUNCTION
- IMPROVE CIRCULATION
- RELIEVE TENSIONS
- TRIM DOWN SPECIFIC AREAS
- FIRM, TIGHTEN AND TONE
- INCREASE VITALITY
- IMPROVE COORDINATION AND BALANCE
- RETARD MUSCLE ATROPHY
- IMPROVE DIGESTION
- IMPROVE ELIMINATION
- REDUCE RESTING HEART RATE
- SLEEP BETTER

OTHER _____

How often do you get regular vigorous exercise (aerobic) of as least 20 to 30 minutes?

- NO REGULAR EXERCISE
- 3-4 TIMES PER WEEK
- DAILY
- 1-2 TIMES PER WEEK
- 5-6 TIMES PER WEEK

Describe in as much detail as possible your current exercise program.

Do you include stretching and flexibility exercises regularly?

- YES
- NO



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Instructor's observations: _____

Release and Indemnification Agreement

I have requested the services of re:fit, inc. ("refit") in connection with a program of physical exercise, which may include Pilates, Feldenkrais™ Method, Gyrotonic®, Yoga, aerobic exercise and/or weight resistance training (the "Program").

I am aware that the Program may involve certain risks of injury, and that I, rather than refit, control the nature and content of the Program. I have been examined by a physician prior to commencing the Program. In consideration of refit's services in connection with the Program, to the fullest extent allowed by law, I assume the risk of any and all accidents, illness and injuries of any kind which may be sustained by me by reason of or in connection with my Program.

In addition, I agree that, to the fullest extent allowed by law, neither refit nor any of its owners, agents, employees, personal representatives, successors, or assigns shall be liable or responsible for or on account of any such accident, illness, or injury, and I release, discharge, and absolve refit and its owners, agents, employees, personal representatives, successors or assigns from any and all liability and responsibility for or on account of any such accident, illness, or injury.

To the fullest extent allowed by law, I shall indemnify, defend and hold harmless refit, its owners, agents, employees, personal representatives, successors, or assigns from any and all losses, liabilities, damage, costs and obligations (or actions or claims in respect thereof) (including reasonable counsel fees), which refit, its owners, agents, employees, personal representatives, successors, or assigns may suffer or incur, insofar, as such losses, liabilities, damages, costs or obligations (or actions or claims in respect thereof) arise out of or are based upon or are in any way connected with my Program.

This Agreement shall be binding upon my heirs, legatees, personal representatives, successors and assigns.

MY SIGNATURE BELOW INDICATES THAT I HAVE READ AND UNDERSTAND THIS AGREEMENT AND AGREE TO BE BOUND BY IT.

SIGNATURE

PRINT NAME

DATE



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Client Cancellation and Payment Policy Information:

Re:fit, inc. clients are seen by appointment only. Scheduling is based on a first come-first served basis. To receive the full benefit of your session, please arrive on time. If you have a standing appointment and are going to be out of town, please let us know as soon as possible.

Cancellation Policy

Cancelling An Appointment With No Charge. To cancel an appointment with no charge we require a twenty-four (24) hour notice. This notice must be given directly to re:fit, inc. by calling 847-657-0881. Notice provided to an instructor is not sufficient.

Cancellation Fee. If you call re:fit, inc. directly and cancel your appointment within 24 hour of the scheduled time, there will be a \$55 cancellation fee for a private lesson, a \$35 cancellation fee for a duet or triplet.

Full Price Required. If you do not call to cancel an appointment, you will be charged the full price of the session.

Payment Policy. You may purchase a 10-pack or pay per session. Cancellations will be billed to the credit card of your choice.

 TYPE

 NUMBER

 EXP. DATE

Collection Action:

I, the undersigned, understand and agree that if collection action should become necessary for recovery of any monies due under services rendered or products purchased, I am responsible for any and all collection costs, court costs, and attorney fees. I also understand and agree that accounts with balances outstanding more than thirty days from the date of service or purchase will be charged a service fee of 5% per month of the outstanding balance, until the balance is paid in full.

By signing below, I agree to abide by the Cancellation and Payment Policies of re:fit, inc.

 CLIENT'S SIGNATURE

 DATE