

# One Human Performance

## *Registration & Consent Form and Health Questionnaire*

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Day Phone: \_\_\_\_\_ Eve Phone: \_\_\_\_\_ Other Phone: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: NJ ZIP: \_\_\_\_\_  
 Email: \_\_\_\_\_

### Program Guidelines

I agree that I will be participating in a group training program that will meet 2x per week on **Tuesdays & Thursdays** at **7:30pm** at **the ONE Montville Center**, and sessions will be **60** minutes in length. The program will run for **4** weeks, from **May 26th** through **June 18<sup>th</sup>**. The total program fee of **\$80** will be paid by check payable to "ONE Human Performance" prior to the commencement of the first training session. I understand that program fees are non-refundable and credit will not be given for missed sessions.

- |  | YES                      | NO                       |
|--|--------------------------|--------------------------|
| 1. Has a doctor ever said you have a heart condition and recommended only supervised physical activity?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Do you have chest pain brought on by physical activity?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Do you tend to lose consciousness or fall over as a result of dizziness?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Has a doctor ever recommended medication for your blood pressure or a heart condition?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you have a bone or joint problem that could be aggravated by the proposed physical activity?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Are you aware, through your own experiences or a doctor's advice, of any physical reason against your exercising without medical supervision? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Are you over the age of 65 and not accustomed to rigorous exercise?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Are you currently or have you been pregnant within the last six months?   | <input type="checkbox"/> | <input type="checkbox"/> |

If you answered YES to one or more of the questions above, please answer the following questions:

- |   |                          |                          |
|---|--------------------------|--------------------------|
| 9. Have you consulted your physician regarding increasing your physical activity and/or performing a fitness assessment?                                  | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. If you answered yes to question 8, will you consult your physician prior to increasing your physical activity and/or performing a fitness assessment? | <input type="checkbox"/> | <input type="checkbox"/> |

Do you now have, have you recently experienced, or have you ever had:  
 (Check all those that apply, leave others blank)

- |  |  |
|--|--|
| <input type="checkbox"/> Heart attack, coronary bypass, or stroke<br><input type="checkbox"/> Extra, skipped or rapid heart beats/palpitations<br><input type="checkbox"/> Asthma, respiratory problems, pulmonary disease<br><input type="checkbox"/> Thyroid Condition<br><input type="checkbox"/> Arthritis, orthopedic problems<br><input type="checkbox"/> Ulcer<br><input type="checkbox"/> Arteriosclerosis<br><input type="checkbox"/> Increased anxiety or depression<br><input type="checkbox"/> Fatigue, lack of energy | <input type="checkbox"/> High/Low Blood Cholesterol<br><input type="checkbox"/> High/Low Blood Pressure<br><input type="checkbox"/> Diabetes<br><input type="checkbox"/> HIV or AIDS virus<br><input type="checkbox"/> Cancer<br><input type="checkbox"/> Neuromuscular disease<br><input type="checkbox"/> Bulimia or Anorexia<br><input type="checkbox"/> Emotional disorders<br><input type="checkbox"/> Trouble sleeping |
|--|--|

By signing below I understand the risks inherent with this event and agree to all program parameters. I do not hold liable One Human Performance Center or any of its representatives or employees. I will notify the proper individuals as to any risk factors and/or medical concerns that may affect my participation.

**Parent Name(s):** \_\_\_\_\_

**Signature:** \_\_\_\_\_