



Advanced
Wellness
Center

**SuperSlow Zone at
Advanced Wellness
Client Intake &
Health Information**



SUPER SLOW
z o n e

MINUTES A WEEK • IN SHAPE FOR LIFE

Date: _____

■ **General Information**

Name: _____ Birthdate: ___/___/___ Gender: Female Male

Address: _____

City: _____ State: _____ Zip: _____

Single Married Widowed Divorced Separated Partnered Other

Phone #'s: Home: _____ Work: _____ Cell: _____

Leave a message? Home Work Cell SS#: _____

E-mail: _____ Web Site: _____

Age: _____ Weight: _____ Height: _____ Date of your last physical: _____

Primary Physician: _____ Phone: _____

Physician Referred – Reason(s): _____

Employer: _____ Occupation: _____ Days off: _____

Spouse's/Partner's name (if applicable): _____ Ages of Children: _____

Spouse's Employer: _____ Spouse's Occupation: _____

Name of person to call in an emergency: _____

Relationship: _____ Phone: _____

How did you hear about us or who referred you to us? _____

Have you ever participated in Physical Therapy? Yes No **If yes, when:** _____

Facility Name: _____ Therapist: _____

Phone: _____ Reason for treatment: _____

Results Achieved: _____

■ Health Information

Are you, or do you think you are, pregnant? Yes No

Are you planning on becoming pregnant? Yes No If yes, approximately when: _____

Allergies to medications or substances: _____

Are you taking any prescribed medications? Yes No

Nerve Pill Pain Killers Muscle Relaxers "Pep" Pills Tranquilizers Insulin Birth Control Pills

If other, please list medications: _____

Are you taking any over-the-counter meds and/or herbs more than once a week? Yes No

If other, please list: _____

Have you had any Past Injuries, Broken Bones, Car Accidents, or Operations in the Past Year

Last Five Years Over Five Years Never? Might this have caused your problem? Yes No

If yes, please explain: _____

Do you have any areas of Weakness, Muscle Tension, Muscle Tightness or Constant Stiffness?

If yes, please explain: _____

Continued on next page →

Do you, or your relatives, have, or have ever had, any of the following : (If yes, when?)

Medical Diagnosis and Health Conditions

Health Condition	Check if YES for You	Check if YES for Your Family (Blood relatives)	When/ Notes
AIDS			
Anemia			
Aneurysms			
Asthma			
Arthritis/Joint Degeneration			
Allergies or sinus			
Attention Deficit/Hyper-activity Disorder			
Cancer			
Carpal Tunnel Syndrome			
Coronary Artery Disease			
Chronic Fatigue Syndrome			
Chronic obstructive respiratory disease (COPD)			
Crohn's			
Diabetes Mellitus			
Pre-Diabetic			
Depression			
Dizziness			
Fainting			
Fibromyalgia/Myofascitis			
GI Problems			
Heart condition			
Headaches			
Hernia			
High Cholesterol			
High Blood Pressure			
Hypoglycemia			
Hypertension			
IBS			
Joint injury or pain: (shoulder, hip, wrist, ankle, elbow, knees, finger, toe)			List joint injury or area(s) of pain:
Low back pain, tension or fatigue			
Lymphodema			
Malnutrition			
Menstrual Irregularities			
Menopause			
Multiple Sclerosis			
Pre-Menopause			
Health Condition	Check if	Check if	When/ Notes

	YES for You	YES for Your Family (Blood relatives)	
Post-Menopause			
Neck pain, tension or fatigue			
Over-weight			
Obesity			
Osteo Arthritis			
Osteoporosis/skeletal health			
Rheumatoid Arthritis			
Rotator Cuff Injury			
Stroke			
Spinal Injury (neck and/or back)			
Tendonitis			
Thyroid Condition			
Surgeries (any type) Pre/Post Surgical Spine Procedures: laminectomy & fusion			Please list surgeries:
Varicose Veins			

■ Payment Information

Who is responsible for your bill: Self Spouse Employer Insurance Other: _____

How Payment will be made: Cash Check Credit Card

If you are here for Medical Care Chiropractic Care and/or Rehab, and ***you are paying by insurance***, please fill out the insurance information:

Worker's Comp Health Insurance Automobile Ins. Policy

Name of Company and Address: _____

Client's Signature

Date



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**SuperSlow Zone at
Advanced Wellness
Fitness & Lifestyle Information**



SUPERSLOW
zone

MINUTES A WEEK • IN SHAPE FOR LIFE

Name: _____ Date: _____

■ **Fitness Information**

I currently have a club membership with: _____ I work out: _____
(Example: morning's 3x a week)

I currently have a Personal Trainer. Our strength training method is: _____

I "self-train" or work out by: _____

If you *don't* currently have a Trainer, have you ever participated in personal training? Yes No

If **yes**, with whom and how long? _____

Describe your *ideal* Personal Trainer? _____

Are you involved in other exercise, sports, or recreational activities? (Please list.)

Current: _____

Future: _____

If you have **personal barriers to exercise**, what are they? _____

How **important and committed** are you to your health and fitness *at this time*? From **1 to 10** I am a ____
(1 is least and 10 is most)

■ **Lifestyle Information**

How long is your work day? _____ Are your work hours: Fixed Flexible

Is your job more physically or mentally demanding? _____

What types of activity does your job regularly require (if it does):

Walking Carrying things Lifting Pushing Pulling Reaching

Other: _____

Do you regularly: travel out of town for work **and/or** pleasure If yes, how much? _____

Your personal and/or work schedule: Is there anything that *might compete* for your exercise time and make it a challenge to *exercise consistently*? _____

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State of Florida as a Health Studio Facility Registration Number: HS6684

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If applicable, how much time do you spend taking care of **children/teenagers**:
(Including activities, school and homework, sports, events, etc.)

- Minimal amount of my time Medium amount of my time A large part of my time

If you could fit your workout ideally into your life, what would it look like? (Please describe how and when.)

If yes to **any** medical diagnosis and/or health conditions (listed on the Client Intake and Health

Information form), has your doctor cleared you for your exercise program? Yes No

Are you currently under a physicians care, including restrictions, for **any** reason? Yes No

If **yes**, please explain: _____

Is there any additional information that your Instructor needs to know in order to keep your program as *safe and productive* as possible?

■ Client Release Form

Name ("The Client"): _____

Informed Consent Between The Client and SuperSlow Zone, ("the Company")

I, _____, have **Agreed to a sample workout** **Enrolled in a program**
of physical activity, including but not limited to, body conditioning machinery used during the workouts
offered by the Company. I affirm that I am in good physical condition and do not suffer from any disability
that would contribute to an injury.

Liability Waiver Between The Client and SuperSlow Zone, (“the Company”)

Participating in an exercise program naturally involves risk of injury to you, whether you or someone else causes it. For and in consideration of the design of an exercise program for the above named client by the Company, the client agrees:

I certify that my answers to the statements listed above are true and complete to the best of my knowledge, and that any exercise program shall be undertaken by the client at his/her sole risk, and release my instructor from all claims, injuries, damages, action or causes of action, and in consideration of my participation in any the Company workshops, workout sessions and/or classes, I release the Company from any claims, demands, and causes of action arising from my participation in an exercise program and from all acts of active or passive negligence on the part of the company, facility, its owner, agents or employees.

I fully understand that I may injure myself as a result of my participation and I release the Company from any liability now or in the future, including but not limited to, heart attacks, muscle strains, muscle pulls or tears, shin splints, heat exhaustion, knee or foot injuries, back injuries and any other illness, soreness or injury caused, occurring during or after my participation at the Company.

The undersigned parties have read, understand, and accept the Informed Consent and Liability Waiver and terms, stated above:

Client's Signature _____
Date

The Center for Advanced Wellness, LLC (D.B.A. SuperSlow Zone) (“the Company”)

By: _____
(Company Representative Signature) _____
Date

Title : _____