

**Please fill out each of the documents contained in the file as thoroughly and accurately as possible.**

If you downloaded the Microsoft Word .doc version of this file, you may directly edit each field. We recommended bold-facing your response for questions which require a “yes” or “no” answer. Once completed save your file, attach to an email, and send instantly it to:

[Bergeron@gonextllc.com](mailto:Bergeron@gonextllc.com)

Pending verification, you will be asked to sign each document during the first meeting with Next Level Performance LLC.

If you downloaded the Adobe .pdf version of this file, print the document and fill in each question by hand. Once finished, mail or fax the completed questionnaire to:

**Fax: 603-216-5529**

**Mail: Next Level Performance LLC  
7 Fairway Drive, #26  
Derry, NH 03038**

Please feel free to call with any questions.



# PAR-Q & YOU

Physical Activity Readiness Questionnaire (A questionnaire for People Aged 15-69)

Regular physical activity is fun and healthy, and increasingly more people are starting to become more active everyday. Being more active is very safe for most people. However, some people should check with their doctor before they start becoming much more active. If you are planning to become much more physically active than you are now, start by answering the eight questions in the box below. If you are between the ages of 15-69, the PAR-Q will tell you if you should check with your doctor before you start. If you are over 69 years of age, and you are not used to being very active, check with your doctor before engaging in physical activity. Common sense is your best guide when you answer these questions. Please read the questions carefully and answer each one honestly.

Check YES OR NO.

YES	NO	
		1. Has your doctor ever said that you have a heart condition <u>and</u> that you should only do Physical activity recommended by a doctor?
		2. Do you feel pain in your chest when you do physical activity?
		3. In the past month, have you had chest pain when you were not doing physical activity?
		4. Do you loose your balance because of dizziness or do you ever loose your consciousness?
		5. Do you have a bone or joint problem that could be made worse by change in physical activity?
		6. Is your doctor currently prescribing drugs (for example, water pills) for you blood pressure or heart condition?
		7. Do you know of <u>any other reason</u> why you should not do physical activity?
		8. Are you currently taking any supplements or pills (e.g. Hydroxycut, Creatine, Xenadrine, Ephedrine, herbal pills or any other weight loss agents)?
		9. Do you require special needs or assistance?
		10. Would you like an orientation to the usage of the equipment and proper training techniques?
		11. Are you Hypoglycemic? (Suffer from low blood sugar levels)
		12. Are epileptic (Suffer from seizures) If yes, when was your last one? _____ Symptoms? _____
		13. Are you Diabetic? If yes, is it controlled by insulin, or medication? _____

**If you answered YES to any of the above answers, you may require Medical Clearance from a qualified physician prior to engaging in an exercise program.**

I have read, understood, and completed this questionnaire. Any questions I had were answered to my full satisfaction.

NAME \_\_\_\_\_ ID NUMBER \_\_\_\_\_

Emergency Contact Name \_\_\_\_\_ Relationship \_\_\_\_\_

Phone Number \_\_\_\_\_ Blood Pressure \_\_\_\_\_

SIGNATURE \_\_\_\_\_ Date \_\_\_\_\_

BIRTHDATE \_\_\_\_\_ (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year)

PAR-Q form (derived from the Canadian Society for Exercise Physiology and ACSM's Guidelines for Exercise Testing & Prescription). Next Level Performance LLC assumes no liability for persons who undertake a physical activity program designed, prescribed, or administered by Next Level Performance LLC.

*Please take a few minutes and complete this form as accurately as possible. This document shall be used to help prescribe an exercise program appropriate for your individual needs.*

**PRE-EXERCISE MEDICAL HISTORY FORM**

Name \_\_\_\_\_ Age \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Occupation \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Doctor's Name \_\_\_\_\_ Phone \_\_\_\_\_

**Check X, IF YES**

**PAST/PRESENT HISTORY DATE**

Have *you* ever had any of the following:

- |                         | <b>DATE</b>    |
|-------------------------|----------------|
| ( ) Rheumatic Fever     | ____/____/____ |
| ( ) Heart Murmur        | ____/____/____ |
| ( ) High Blood Pressure | ____/____/____ |
| ( ) Any Heart Problem   | ____/____/____ |
| ( ) Disease of Arteries | ____/____/____ |
| ( ) Varicose Veins      | ____/____/____ |
| ( ) Lung Disease        | ____/____/____ |
| ( ) Operations          | ____/____/____ |
| ( ) Epilepsy            | ____/____/____ |
| ( ) Cancer              | ____/____/____ |
| ( ) Anemia              | ____/____/____ |
| ( ) Asthma              | ____/____/____ |
| ( ) Injury to the Body  | ____/____/____ |
| ( ) Eating Disorders    | ____/____/____ |

Explain: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**FAMILY HISTORY (AGE) RELATIVE**

Has any of *your relatives* ever had any of the following:

- |                              | <b>DATE</b>    |
|------------------------------|----------------|
| ( ) Heart Attack             | ____/____/____ |
| ( ) High Blood Pressure      | ____/____/____ |
| ( ) High Cholesterol         | ____/____/____ |
| ( ) Diabetes                 | ____/____/____ |
| ( ) Congenital Heart Disease | ____/____/____ |
| ( ) Heart Operations         | ____/____/____ |
| ( ) Cancer                   | ____/____/____ |
| ( ) Stroke                   | ____/____/____ |
| ( ) Other                    | ____/____/____ |

Explain: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**PRESENT SYMPTOMS REVIEW**

Have you recently had any of the following:

- |                                       |                |
|---------------------------------------|----------------|
| ( ) Chest Pain                        | ____/____/____ |
| ( ) Shortness of Breath               | ____/____/____ |
| ( ) Heart Palpitations                | ____/____/____ |
| ( ) Cough on Exertion                 | ____/____/____ |
| ( ) Coughing up Blood                 | ____/____/____ |
| ( ) Back Pain                         | ____/____/____ |
| ( ) Swollen, stiff, or painful joints | ____/____/____ |

Explain: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**RISK FACTORS**

YES NO

**1. SMOKING**

Cigarettes ( ) ( ) How many per day? \_\_\_\_\_ How many yearly? \_\_\_\_\_  
Cigar ( ) ( ) How many per day? \_\_\_\_\_ How many yearly? \_\_\_\_\_  
Pipe ( ) ( ) How many per day? \_\_\_\_\_ How many yearly? \_\_\_\_\_

How old were you when you started? \_\_\_\_\_  
In case you have stopped, when did you stop? \_\_\_\_\_  
Why? \_\_\_\_\_

**2. DIET**

What is your weight now? \_\_\_\_\_ lbs One year ago \_\_\_\_\_ lbs At age 21 \_\_\_\_\_  
Are you dieting? \_\_\_\_\_ Why? \_\_\_\_\_  
What diet plan? \_\_\_\_\_ Under doctor's care? \_\_\_\_\_

**3. EXERCISE**

Do you engage in any exercise, fitness, or recreational activities? \_\_\_\_\_  
If so, what? \_\_\_\_\_ How often? \_\_\_\_\_  
How far do you walk each day? \_\_\_\_\_  
Is your occupation: Sedentary \_\_\_\_\_ Inactive \_\_\_\_\_ Active \_\_\_\_\_ Heavy Work \_\_\_\_\_  
Do you have discomfort, shortness of breath, or pain with moderate exercise? \_\_\_\_\_  
Were you a high school athlete? \_\_\_\_\_ Specialty: \_\_\_\_\_

**MARK ANY PILLS YOU ARE NOW TAKING**

\_\_\_\_\_ Mood elevators (pills of depression)  
\_\_\_\_\_ Pep or diet pills (such as dexadrine)  
\_\_\_\_\_ tranquilizers, sedatives, nerve or sleeping pills (Milltown, Librium, Phenobarbital, Nembutal)  
\_\_\_\_\_ Pain Relief Medicine (Demoral, Codeine, Morphine, etc.)  
\_\_\_\_\_ Antihistamines or allergy pills  
\_\_\_\_\_ Other blood pressure pills  
\_\_\_\_\_ Other

Explain: \_\_\_\_\_  
\_\_\_\_\_

*I have read this evaluation form completely and certify that the information I have provided is true and accurate to the best of my knowledge.*

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# CONSENT - RELEASE FORM

## For Health & Fitness Testing and/or Sports Testing & Evaluations

I, the undersigned, do hereby acknowledge:

- my consent to perform a fitness test consisting of: flexibility tests for the upper body, trunk, lower back, and legs; measurements of: standing height, weight, girths and skin folds; and tests of: pushups for upper body; curl ups, resting heart rate and blood pressure, and trunk forward flexion, for the purposes of determining the type and amount of physical activity most appropriate for my level of fitness;
- my consent to perform a sport test consisting of: flexibility tests for the upper body, trunk, lower back, and legs; measurements of: standing height, weight, girths and skin folds; and tests of: near maximum effort bench press, back squats, deadlifts, or other strength exercises; physical evaluation through the pro-agility test, vertical jump test, horizontal jump test, standing triple jump test, conditioning shuttle tests, sprint and agility tests, plyometric hurdling test, cardiovascular endurance tests such as the mile run, overhead shot throw test; and other tests which will be fully explained to me if not already specified in this consent – release form; for the purposes of determining the type and amount of physical activity most appropriate for my level of fitness and for athletic evaluation purposes;
- my understanding that the heart rate and blood pressure may be measured prior to and following all tests;
- I understand that the interpretation of the results is limited to providing a comparison with percentile-based norms and information on varying aspects of fitness. I also understand that Next Level Performance LLC is not a certified nor a recognized medical doctor/physician, and that I approve these tests to use for evaluation and exercise prescription by Next Level Performance LLC;
- my understanding that there are potential risks such as but not limited to: episodes of transient lightheadedness, fainting, abnormal blood pressure, chest discomfort, leg cramps and nausea, and that I assume willfully those risks;
- my obligation to immediately inform Next Level Performance LLC of any pain, discomfort, fatigue , or any other symptoms that I may suffer during and immediately after the testing;
- my understanding that I may stop or delay any further testing if I so desire and that the testing may be terminated by Next Level Performance LLC upon observation of any symptoms of distress or of abnormal response;
- my understanding that I may ask questions or request further explanation or information about the procedures at any time before, during, and after the testing;
- that I hereby release Next Level Performance LLC from any liability with respect to any damage or injury (including death) that I may suffer during the administration of these tests due to circumstances beyond the control of or prior knowledge provided directly to Next Level Performance LLC.

\_\_\_\_\_  
Signature of Client

\_\_\_\_\_  
Date

\_\_\_\_\_  
Agent of Next Level Performance LLC



**Next Level  
Performance**

WHERE POTENTIAL MEETS REALITY

\_\_\_\_\_  
Date

# CONSENT - RELEASE FORM

## For In-Home Personal Training and/or On-Site Sports Training

I, \_\_\_\_\_, the undersigned, do hereby acknowledge:

- that I am agreeing to a contract for a given period of time, called sessions, in which I am to be trained by Next Level Performance LLC;
- that I have received prior physician clearance. In the event that I have not, I am agreeing that I am aware that physician clearance is necessary and that I am waiving my right to challenge against this should an injury occur due to an incident which may have been preventable had I received physician clearance;
- I understand training outdoors poses the potential risk of major injury due to uneven ground, slick surfaces, inclement weather, and other environmental factors,
- I understand that exercising in the presence of thunder and lightning outdoors is not permitted by guidelines of the National Athletic Training Association storm advisory guidelines,
- I understand that each and every session is planned by Next Level Performance LLC, and therefore I am under the strict guidance of Next Level Performance LLC;
- my understanding that there are potential risks such as but not limited to: episodes of transient lightheadedness, fainting, abnormal blood pressure, chest discomfort, leg cramps and nausea, as a result of training, and that I assume willfully those risks;
- my obligation to immediately inform Next Level Performance LLC of any pain, discomfort, fatigue, or any other symptoms, or problems with my training, that I may suffer during and immediately after a training session;
- that this contract is non-cancellable, non-transferable, and non-refundable
- that **cancellation of a training session must occur at least 48 hours before a scheduled session** or within reasonable time, whichever Next Level Performance LLC deems fair, or the lost session shall be non-transferable, and non-refundable;
- that in the event that I do not wish to work with Next Level Performance LLC any longer, it is at the discretion of Next Level Performance LLC to whether I have a right to a 50% refund to remaining contracted sessions if any, within good reason.
- that I hereby release all agents, officers and employees of Next Level Performance LLC from any liability with respect to any damage or injury (including death) that I may suffer during any of my sessions.

\_\_\_\_\_  
Signature of client

\_\_\_\_\_  
Date

\_\_\_\_\_  
Agent of Next Level Performance LLC

\_\_\_\_\_  
Date



**Next Level  
Performance** LLC  
WHERE POTENTIAL MEETS REALITY

## Personal Fitness Profile

**Name:** \_\_\_\_\_

**Client No:** \_\_\_\_\_

**Address:** \_\_\_\_\_  
street city state zip code

**Home Phone:** \_\_\_\_\_

**Work Phone:** \_\_\_\_\_

**Email:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_

**Age:** \_\_\_\_\_

**Sex:** \_\_\_\_\_

**In Case of Emergency Contact:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**None of the following questions are for diagnostic or treatment purposes**

1. What is your level of physical activity?

Yes No

a. Do you currently exercise? If yes, how many times per week \_\_\_\_\_ and for how long? \_\_\_\_\_

b. If no, have you exercised in the past?

c. Have you ever participated in a personal training program?

2. If you currently exercise, what exercise activities does your program include?

3. What are your short and long term goals for exercise, health and fitness?

4. Do you have any other comments regarding your level of fitness or your fitness needs?

HAVE YOU EVER BEEN DIAGNOSED WITH, OR SUFFERED FROM:

Heart attack / heart disease

Other cardiac surgery

Embolism

Aneurysm

Coronary bypass

Pacemaker

Stroke

Angina Pectoris

If you answered “**YES**” to any of the above conditions, **STOP** here and inform the trainer.  
You must have medical clearance before exercising.



Please provide the following information:

1. Have you ever been diagnosed with or do you have any of the following:

- |  |   |
|--|---|
| <input type="checkbox"/> Peripheral vascular disease | <input type="checkbox"/> Thyroid problem    |
| <input type="checkbox"/> Phlebitis                   | <input type="checkbox"/> Chronic bronchitis |
| <input type="checkbox"/> Emphysema                   | <input type="checkbox"/> Diabetes           |
| <input type="checkbox"/> Asthma                      |   |

2. Do you frequently experience any of the following:

- |   |  |
|---|--|
| <input type="checkbox"/> Chest pain                               | <input type="checkbox"/> Lightheadedness or fainting |
| <input type="checkbox"/> Palpitations                             | <input type="checkbox"/> Heart murmur                |
| <input type="checkbox"/> Breathlessness that awakens you at night | <input type="checkbox"/> Shortness of Breath         |
| <input type="checkbox"/> Ankle swelling                           | <input type="checkbox"/> Claudication                |
| <input type="checkbox"/> Dizziness                                |  |

**If you checked any of the above, you will be given Recommendation A**

3. Check if you have:

- High blood pressure > 160 / 90
- High Cholesterol > 240
- Smoked Cigarettes (please give details):
- Family history of coronary or other atherosclerotic diseases in parents or siblings prior to age 55

**If you have checked two (2) or more above, or if you are a male, 40 years or older, or female, 50 years or older you will be given Recommendation B**

4. Are you currently pregnant? Yes No

5. Are you presently taking any medication? Yes No

If yes, name and dosage: \_\_\_\_\_

6. Are you presently on a special diet? Yes No

If yes, describe: \_\_\_\_\_

7. Do you have any physical condition, impairment, or disability that might affect your ability to undertake an exercise program? Yes No

If yes, please explain: \_\_\_\_\_

***I have read this evaluation form completely and certify that the information I have provided is true and accurate to the best of my knowledge.***

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