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REGISTRATION FORM (Confidential)

DATE: _____

NAME: **(Last,** **First,** **Middle):**
_____

SCHOOL/TEAM: _____ LEVEL**:** Pro/College/Amateur/Junior/Other

SPORT: _____ **POSITION:** _____

GOALS: _____

HEALTH and LIFESTYLE:
Please describe your current activity level (please be honest so that we can best tailor your program):
□ Sedentary (desk job or inactive lifestyle, no exercise)
□ Mild exercise (e.g., active lifestyle, climb stairs, walk 3 blocks, light golf)
□ Occasional vigorous exercise (e.g., work or recreation, less than 4x per week for 30 minutes)
□ Regular vigorous exercise (e.g., work or recreation 4x/week for 30 minutes or more)

What is your current occupation? _____

Average daily stress level (circle one): (LOW) **1 2 3 4 5 6 7 8 9 10** (HIGH)

Please list your current exercise activities: _____
_____

Describe other fitness experience: _____
_____

Are you on a special diet or eating program? If yes, please describe: _____
_____

UpRight Movement PROGRAMS:

FEEL BETTER □ MOVE BETTER □ PERFORM BETTER □

Movement 101 □ Training □

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MAILING ADDRESS: **BILLING ADDRESS: (If Different)**

Street: _____ Apt _____

City:

_____

State:

_____ Zip _____

Street: _____ Apt _____

City:

_____

State:

_____ Zip _____

E-MAIL:

_____

PHONE:

Home: _____ Cell: _____

Business: _____ Fax: _____

PERSONAL INFORMATION:

DOB: (mm/dd/yy): _____ Age: ____ GENDER: Male _____ Female _____

Marital Status: S _____ M _____

Spouse's name: _____ DOB: (mm/dd/yy): _____

Child's Name: _____ DOB: (mm/dd/yy): _____

Child's Name: _____ DOB: (mm/dd/yy): _____

EMERGENCY CONTACT INFORMATION: **EMERGENCY PHONE:**

Name: _____ Home: _____

Relation: _____ Cell: _____

OPTIONAL: I would like to take part in positive promotional opportunities on my work and accomplishments with **UpRight Movement**. Yes / No

Payment/Cancellation Policy: Applicable payment is due at the time of any appointment, and cancellation must be made at least 24 hours prior to appointment to avoid full charge. There is a $25 returned check fee.

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PAST MEDICAL HISTORY FORM (Confidential)

Regular physical activity is fun and healthy, and increasingly more people are starting to become more active every day. Being more active is very safe for most people. However, some people should check with their doctor before they start becoming much more physically active.

If you are planning to become much more physically active than you are now, start by answering the questions below. If you are between the ages of 15 and 60, this questionnaire will tell you if you should check with your doctor before you start. If you are over 60 years of age, and you are not used to being very active, check with your doctor.

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**.

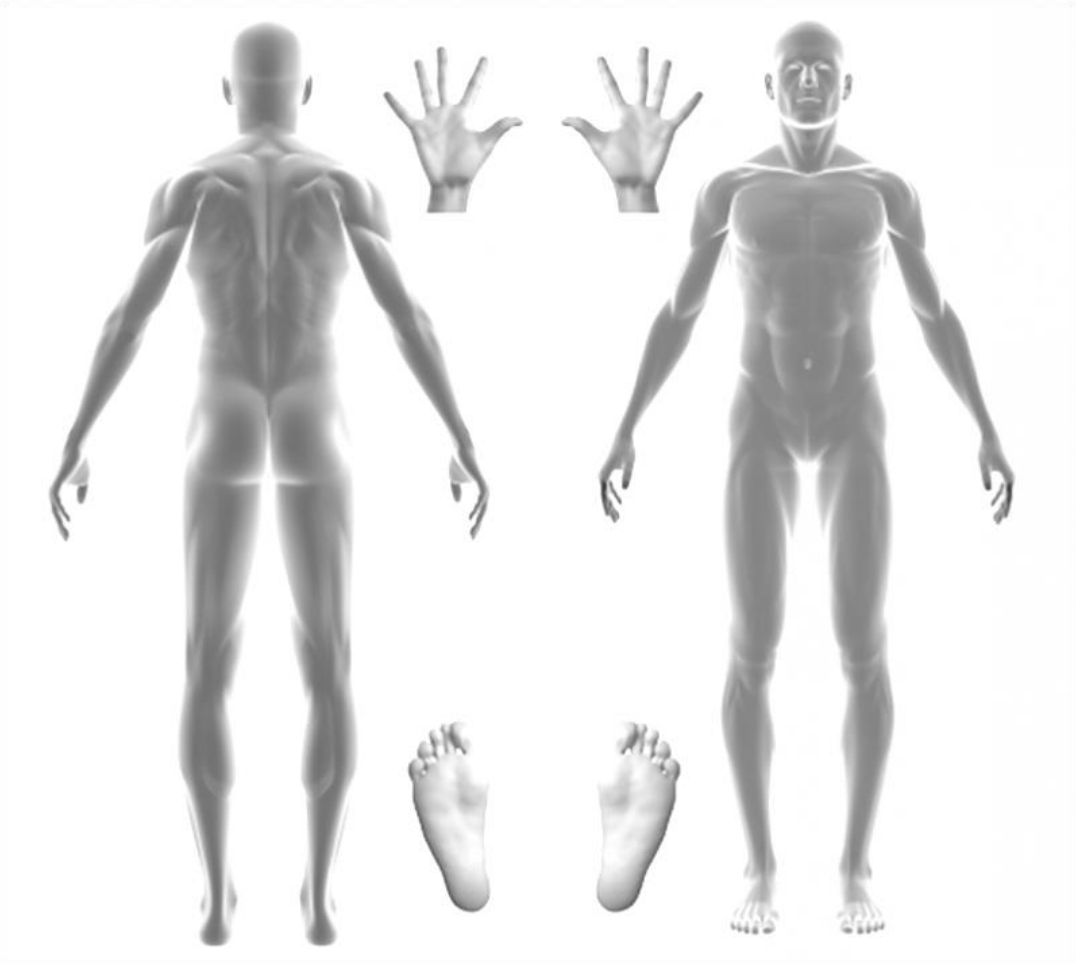
Client Name: _____ Date: _____

1. Have you had an injury before? ☐ **Yes** ☐ **No**
   If yes, please list your injuries (most recent first, with dates):
   _____
   _____
   _____
   _____
   _____
   _____

2. Check which apply to your current condition:
   ☐ Athletic injury ☐ Work related injury ☐ Injury related to lifting
   ☐ Other _____
   ☐ Cause unknown ☐ Injury related to falling ☐ Motor vehicle accident

3. Have you had a surgery related to any of your injuries? ☐ **Yes** ☐ **No**
   If yes, please specify the date:
   _____
   _____
   _____
   _____
   _____
   _____

4. Mark on the body of the diagram the area and most appropriate description of what you are chronically experiencing. How would you rate your level of pain? (LOW) **1 2 3 4 5 6 7 8 9 10** (HIGH). What activities/positions aggravate your condition?



_____

_____

_____

_____

5. Have you seen, or are you currently seeing any other practitioner for your current physical pain or fitness goals?

Name/Type of Practitioner Treatment Provided

_____

_____

6. If you are female, is it possible you are pregnant? □ **Yes** □ **No**

Do you have, or have you had, any of the following:

Has your doctor ever said that you have a heart condition and that you should only do physical activity recommended by a doctor? □ **Yes** □ **No**

Do you feel pain in your chest when you do physical activity? □ **Yes** □ **No**

In the past month, have you had chest pain when you were not doing physical activity? □ **Yes** □ **No**

Do you lose your balance because of dizziness or do you ever lose consciousness? □ **Yes** □ **No**

Do you have a bone or joint problem (for example, back, knee or hip) that could be made worse by a change in your physical activity? □ **Yes** □ **No**

Is your doctor currently prescribing drugs (for example, water pills) for your blood pressure or heart condition? □ **Yes** □ **No**

Do you know of any other reason why you should not do physical activity? □ **Yes** □ **No**

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	Yes	No		Yes	No
Diabetes	☐	☐	Hypoglycemia	☐	☐
Chest Pain/Angina	☐	☐	Osteoarthritis	☐	☐
High Blood Pressure	☐	☐	Osteoporosis	☐	☐
Heart Disease	☐	☐	Hernia	☐	☐
Heart Attack	☐	☐	Seizures	☐	☐
Heart Palpitations	☐	☐	Metal Implants	☐	☐
Pacemaker	☐	☐	Dizziness/Fainting	☐	☐
Headaches	☐	☐	Fractures	☐	☐
Kidney Problems	☐	☐	Surgeries	☐	☐
Cancer	☐	☐	Skin Abnormalities	☐	☐
	Yes	**No**		**Yes**	**No**
Stroke	☐	☐	Nausea/Vomiting	☐	☐
Bowel/Bladder Dysfunction	☐	☐	Ringing in Your Ears	☐	☐
Urine Leakage	☐	☐	Rheumatoid Arthritis	☐	☐
Asthma/Breathing Problems	☐	☐	Smoking/Tobacco Alcohol/Drugs	☐	☐
Liver/Gallbladder Problems	☐	☐	Difficulty breathing	☐	☐
Shortness of breath at rest or upon mild exertion	☐	☐	High cholesterol	☐	☐
Swollen ankles (due to circulation or metabolic condition)	☐	☐	Family history of heart disease	☐	☐
Physical Limitations	☐	☐	Other	☐	☐

If you answered **YES** to any of the items above, please briefly explain and give the date. Include any other pertinent information regarding your past medical history:

_____

7. Do you have any allergies (including medicines or supplements)? ☐ **Yes** ☐ **No**
   If yes, please explain_____

8. Are you presently taking any medications, over the counter or prescribed? ☐ **Yes** ☐ **No**
   If yes, please list the medications and what condition it is for:

_____

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The above **PAST MEDICAL HISTORY FORM** questionnaire is meant to identify some obvious health problems that may limit your participation in exercise/or physical testing. Your acceptance into this program does not limit the possibility of undetected health problems. We urge you to see your physician regularly and to report any unusual symptoms you may encounter. You should report any unusual signs or symptoms that occur during exercise to your performance specialist and health professional.

Yes to one or more questions Talk with your doctor by phone or in person BEFORE you start becoming much more physically active or BEFORE you have a fitness appraisal. Tell your doctor about the **PAST MEDICAL HISTORY FORM** questionnaire and which questions you answered **YES**.

- You may be able to do any activity you want — as long as you start slowly and build up gradually. Or, you may need to restrict your activities to those, which are safe for you. Talk with your doctor about the kinds of activities you wish to participate in and follow his/her advice.
- Find out which community programs are safe and helpful for you.

No to all questions

If you answered **NO** honestly to all questions, you can be reasonably sure that you can:

- start becoming much more physically active – begin slowly and build up gradually. This is the safest and easiest way to go.
- take part in a fitness appraisal – this is an excellent way to determine your basic fitness so that you can plan the best way for you to live actively. It is also highly recommended that you have your blood pressure evaluated. If your reading is over 144/94, talk with your doctor before you start becoming much more physically active.

DELAY BECOMING MUCH MORE ACTIVE:

- if you are not feeling well because of a temporary illness such as a cold or a fever – wait until you feel better; or
- if you are or may be pregnant – talk to your doctor before you start becoming more active.

PLEASE NOTE:

If your health changes so that you then answer **YES** to any of the above questions, tell your performance specialist and health professional. Ask whether you should change your physical activity plan.

Informed Use of the PAST MEDICAL HISTORY FORM questionnaire: UpRight Movement, and their agents assume no liability for persons who undertake physical activity, and if in doubt after completing this questionnaire, consult your doctor prior to physical activity.

NOTE: If the PAST MEDICAL HISTORY FORM questionnaire is being given to a person before he or she participates in a physical activity program or a fitness appraisal, this section may be used for legal or administrative purposes.

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

NAME _____

SIGNATURE _____

SIGNATURE OF PARENT or LEGAL GUARDIAN (for participants who are minors)

_____

_____ DATE

Note: This physical activity clearance is valid for a maximum of 12 months from the date it is completed and becomes invalid if your condition changes so that you would answer YES to any of the above questions.

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RELEASE AND WAIVER OF LIABILITY

I understand that this Release And Waiver Of Liability governs all rights and liabilities relating in any way to the receipt by me from UpRight Movement. and/or its agents of Services, as that term is defined below. I have read, understand, and agree to be bound by the terms below.

Definitions

"Services" shall mean any and all manner of goods and services offered by UpRight Movement or any other Released Party to you. These services, which may take the form of training, treatment, consulting, and the like, expressly include but are not limited to: evaluations; rehabilitation; reconditioning; performance planning; performance training (including strength & conditioning training, speed & quickness training, plyometric training, and the like); recovery and regeneration training; sports nutrition consultation; supplement and nutrition provision; any consultation related to any item in this list; injury reduction and treatment; technical and tactical instruction; performance enhancement.
"Training" shall mean any act, omission, or other activity required of you or carried out by you in relation to the Services.
"**Released Parties**" shall mean all agents of services, any and all representatives of UpRight Movement, all of their officers, directors, shareholders, insurers, partners, employees, employers, agents, successors, contractors, assigns, affiliates, parent corporations, affiliated corporations, and subsidiary corporations.

Terms And Provisions

The risk of injury from participation in sporting events and other strenuous physical activity, including Training, is significant, including the potential for permanent paralysis, other serious injury, and/or death. **I KNOWINGLY AND FREELY ASSUME ALL SUCH RISKS** of participation in Training, including, without limitation, risk arising from or relating in any way to the condition of the facilities, equipment, fields, other training environments, and surrounding premises, the actions of persons other than myself, my own actions, and travel to and from the Training. **I UNDERSTAND THAT THE RELEASED PARTIES MAKE NO WARRANTIES** and shall in no event be responsible or liable for the defective or dangerous condition of the facilities, equipment, fields, and surrounding premises, except to the extent such condition(s) result(s) solely from the gross negligence or intentional acts of a Released Party.

I AGREE THAT THE RELEASED PARTIES SHALL NOT BE LIABLE for any claims, demands, injuries, damages, actions, or causes of action that arise in whole or in part due to the simple negligence of the Released Parties, or any of them. **FURTHERMORE, I FOREVER RELEASE AND DISCHARGE, AND AGREE TO INDEMNIFY AND HOLD HARMLESS**, the Released Parties from and in relation to all claims, demands, injuries, damages, actions, or causes of action that arise from or relate in any way to my participation in the Training, other than such claims, demands, etc. that arise solely from the gross negligence or intentional acts of a Released Party. **I FURTHER WARRANT AND CERTIFY** that I have no health conditions or defects that would prevent me from participating safely in the Training, that I have consulted and been cleared by a medical doctor in relation to such participation, and that I am otherwise sufficiently fit and healthy to so participate.

IN ANY EVENT, THE LIABILITY OF A RELEASED PARTY TO ME FOR ANY REASON AND UPON ANY CAUSE OF ACTION SHALL NOT EXCEED THE AMOUNT ACTUALLY PAID BY ME TO UpRight Movement DURING THE TWELVE MONTHS IMMEDIATELY PRECEDING MY ASSERTION OF SUCH CLAIM. THIS LIMITATION APPLIES TO ALL CAUSES OF ACTION IN THE AGGREGATE, INCLUDING, WITHOUT LIMITATION, TO BREACH OF CONTRACT, BREACH OF WARRANTY, NEGLIGENCE, STRICT LIABILITY, MISREPRESENTATIONS, AND OTHER TORTS.

If any paragraph, subparagraph, sentence, or clause of this Agreement shall be adjudged illegal, invalid, or unenforceable, the balance of the Agreement shall remain in full force and effect. This Agreement shall be construed and interpreted under California Law. Any lawsuit or claim arising from or relating in any way to Training, Services, and/or this Agreement shall be brought, if at all, in Humboldt County, California. **I have read this Agreement, fully understand its terms, understand that I have given up substantial rights by signing it, and sign it freely and voluntarily. I acknowledge that I have received valuable consideration in relation to my execution of this Agreement, which I understand to be a prerequisite to my receipt of Services. Finally, I understand that this Agreement shall be of full force and effect as to any and all Services I receive from the Released Parties, without regard to the date or timing of such service.**

_____	_____	_____
Name	**Signature/Parent/Legal Guardian**	**Date**