

Results Personal Training
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978.664.2107
Service Agreement

This agreement made this ____ day of _____, 20__ by and between **Results Personal Training DBA** and _____ (“Client”) whereby Company agrees to provide Fitness Training services to Client (or Client’s child) in accordance with a training plan developed by Results Personal Training on the following terms and conditions.

Personal Training Terms and Conditions

Training Sessions will follow a structured timeframe with rates based upon an hourly fee and applied package discounts for services provided, agreed to and payable in advance. Training will take place at dates and times mutually agreed upon in advance by both parties. Training that is not rescheduled or cancelled by Client within 24 hours, or when Client does not arrive within 15 minutes of the scheduled start time, will result in forfeiture of the Training Session. Client agrees to be charged on an individual basis for all forfeited Training Sessions. At any time, either party may terminate this Agreement by delivering written notice to the other party, however such termination shall not relieve Client of his/her financial obligations under this paragraph.

Client agrees to wear clothing appropriate for physical activity and be ready to participate in the Training at the scheduled start time. If Client is not prepared to begin at the scheduled time, such time will be deducted from that particular Training Session. Further, Client agrees to conduct him/herself in a courteous and professional manner at all times. Failure to wear appropriate clothing or behave accordingly is grounds for Results Personal Training to terminate the Training Session(s) at Client’s sole expense.

Client must complete the Health History and Fitness Summary attached hereto as Annex A and by this reference incorporated herein. Results Personal Training may require advanced written approval from Client’s (or Client’s child’s) physician regarding participation in Training.

Client agrees to indemnify and hold harmless Results Personal Training, its members, employees and agents of and from any and all actions, causes of action, claims, demands, damages, costs, debts, fees and expenses, including attorney’s fees, that Results Personal Training may have to pay in connection with the loss of life, personal injury, and/or damage to property or equipment on account of or in any way arising, directly or indirectly, from any act or omission by Client (or Client’s child) and/or all those claiming by, through or under Client (or Client’s child), in any way connected to this Agreement.

This Agreement (including Annex A and the current Price List) is the entire agreement between the parties and replaces and supercedes all prior and contemporaneous communications between the parties.

This Agreement shall be construed and enforced in accordance with the laws of the State of Massachusetts, without giving effect to the conflict of law principles thereof, and the parties hereby consent to exclusive jurisdiction of the state and federal courts located in Massachusetts for any litigation. RESULTS PERSONAL TRAINING’S SOLE OBLIGATION IS THE DELIVERY OF SERVICES AS STATED HEREIN. IN NO EVENT SHALL COMPANY BE LIABLE FOR CONSEQUENTIAL, SPECIAL, INCIDENTAL OR SIMILAR DAMAGES, SUCH AS (BUT NOT LIMITED TO) LOSS OF INCOME, REVENUE, PROFITS OR CONSORTIUM RESULTING FROM CLIENT’S (OR CLIENT’S CHILD’S) PARTICIPATION IN TRAINING, EVEN IF RESULTS PERSONAL TRAINING HAS

BEEN ADVISED OF THE POSSIBILITY OF SUCH DAMAGES, OR FOR DAMAGES OR FOR ANY CLAIM BY ANY THIRD PARTY. IN NO EVENT SHALL ANY LIABILITY OF RESULTS PERSONAL TRAINING EXCEED THE AMOUNT PAID FOR THE SERVICES BY CLIENT. CLIENT ACKNOWLEDGES THAT THE AMOUNT PAID BY CLIENT FOR THE SERVICES HEREUNDER REFLECTS THIS ALLOCATION OF RISK. SOME STATES DO NOT ALLOW THE LIMITATION OR EXCLUSION OF LIABILITY FOR INCIDENTAL OR CONSEQUENTIAL DAMAGES, SO THE ABOVE LIMITATION OR EXCLUSION MAY NOT APPLY.

Assumption of Risks and Personal Responsibility

Client acknowledges that participation in Training is not without risks and certain risks cannot be eliminated. Client understands that Client's (or Client's child's) participation in Training can result in or cause loss or damage to equipment and bodily injury, illness, permanent disability or even death. Client agrees that Client is responsible for Client's (or Client's child's) health and safety at all times and agrees to assume responsibility for all risks identified herein and those inherent risks not specifically identified. Client understands that Client's (or Client's child's) participation in Training is voluntary and elects to participate in spite of and with full knowledge of all risks.

Client is aware that the Training will require a high level of physical exertion. Client has consulted and verified with physician or other medical professionals that Client (or Client's child) has no past or current physical or psychological condition(s) that may affect Client's (or Client's child's) participation in the Training. Client certifies that Client (or Client's child) is fully capable of participating in Training without causing harm to himself/herself or others. Therefore, Client expressly assumes full responsibility for Client's (or Client's child's) loss of personal property, bodily injury, illness, permanent disability or death and all other expenses suffered as a result of any and all risks associated with the delivery of Services and the participation in Training, including without limitation negligence, and hereby expressly waive all claims in advance.

The parties accept the terms and conditions stated herein and acknowledge that this Agreement is effective and binding on Client's (or Client's child's) heirs, assigns, personal representatives and estate.

CLIENT

Client's Signature: _____

Address: _____

Print Name: _____

Parent's Signature (if under 18): _____

Phone Number: _____

Print Name: _____

Email: _____

COMPANY

By: _____

Randy Robitaille, Sole Member

Results Personal Training Health History & Fitness Summary

I. Administrative Information

Name _____
Mailing Address _____
City: _____ State _____
Zip Code: _____
E-mail: _____
Date of birth: _____
Primary Care Physician: _____
Emergency Contact: _____
Relationship of emergency contact: _____

Date: _____
Phone (H): _____
Phone (W): _____
Mobile/Cell: _____
Gender (circle one) male female
Phone #: _____
Phone #: _____

II. Medical History

Date of last medical physical exam _____ Date of last physical fitness test _____
Circle any who died of heart attack before age 50: **father mother brother sister grandparent**
Circle any operations you have had: **back heart kidney eyes joint neck ears hernia lung**
Date(s) of the above operations _____
Other operations: _____
Circle any medications taken in last 6 months: **blood thinner epilepsy nitroglycerin diabetic heart rhythm medication digitalis high blood pressure diuretic insulin**
Please indicate any other medication and its use: _____

Please circle any of the following for which you currently have or have been diagnosed or treated by a physician or health professional:

- | | | | |
|------------------------|--------------------|------------------------------|----------------------|
| Abnormalities | Cancer | Heart Problems | Obesity |
| Alcoholism | Chest pain/angina | Hepatitis A B C | Osteoporosis |
| Allergies | Chronic fatigue | Hernia | Pacemaker |
| Allergic to heat | Cirrhosis | High blood pressure | Phlebitis |
| Allergic to cold | Concussion | HIV | Rheumatoid arthritis |
| Anemia | Congenital defect | Hyperlipidema | Skin abnormalities |
| Back Strain | Emphysema | Kidney problems | Smoking |
| Bleeding trait | Epilepsy | Liver/ gall bladder problems | Special diet |
| Bladder problems | Eye problems | Mental illness | Stroke |
| Bowel problems | Frequent headaches | Mononucleosis | Thyroid problem |
| Breathing difficulties | Gout | Neck strain | Ulcer |
| Bronchitis | Hearing loss | Other: _____ | |

Please explain status of any previously circled answers: _____

Please specify any allergies you have & if life threatening: _____

If being seen post injury rehabilitation, please indicate the date(s) of injury: _____

Did you have surgery related to this injury: If so, indicate the date(s) of surgery: _____

Please describe how you injured yourself: _____

Please circle the number indicating how often you have had the following health symptoms:
(5 = very often, 4 = fairly often, 3 = sometimes, 2 = infrequently, 1 = practically never, 0 = never)

- | | | | |
|----------------------|-------------|--------------------------------------|-------------|
| abdominal pain | 0 1 2 3 4 5 | feel faint | 0 1 2 3 4 5 |
| low back pain | 0 1 2 3 4 5 | dizziness | 0 1 2 3 4 5 |
| arm or shoulder pain | 0 1 2 3 4 5 | breathless with exertion | 0 1 2 3 4 5 |
| leg pain | 0 1 2 3 4 5 | palpitations or fast heart | 0 1 2 3 4 5 |
| chest pain | 0 1 2 3 4 5 | unusual fatigue with normal activity | 0 1 2 3 4 5 |
| swollen joints | 0 1 2 3 4 5 | cough up blood | 0 1 2 3 4 5 |

III. Fitness Summary

Please circle or indicate answers to the following:

Height: _____ Weight now: _____ Weight one year ago: _____ Weight at Age 21: _____

Do you use Tobacco? **Yes No** If yes, number of cigarettes, cigars, tips, or packs of chew per day _____

Do you exercise regularly? **Yes No** How long have you been exercising regularly? _____ months _____ years

Do you do regular cardiovascular exercise? **Yes No** If so, how much? Minutes/day _____ Days/week _____

How much time are you willing to devote to an exercise program? Minutes/day _____ Days/week _____

Do you know what your cholesterol level is? Total _____ HDL _____ LDL _____ or HDL:LDL ratio: _____

Number of hours worked per week: _____ Or retired? **Yes No**

Majority of work time spent (circle): **sitting at desk lifting loads standing walking/driving**

How many days per week do you accumulate 30 minutes of moderate activity? _____

How many days per week do you spend at least 20 minutes of vigorous exercise? _____

Can you jog 3 miles at a moderate pace without discomfort? **Yes No**

Can you walk 1 mile without fatigue? **Yes No** Can you walk 4 miles briskly without fatigue? **Yes No**

Please list sports done as a child/teenager: _____

Please list sports done as an adult: _____

Please list sports or activity currently involved in: _____

Do you keep a training or exercise log? **Yes No**

Do you need an inhaler for exercise? **Yes No**

Please list anything not included on this questionnaire that may cause you problems during a fitness test or fitness program:

Please indicate what your goal is/are for the Personal Training programs:

- | | | |
|---|---|---|
| <input type="checkbox"/> Sport conditioning | <input type="checkbox"/> Weight loss | <input type="checkbox"/> Reduce blood pressure |
| <input type="checkbox"/> Improve speed, power, strength | <input type="checkbox"/> Increase general fitness | <input type="checkbox"/> Improve cholesterol levels |
| <input type="checkbox"/> Increase muscle mass | <input type="checkbox"/> Increase energy levels | <input type="checkbox"/> Increase bone mass |
| <input type="checkbox"/> Improve endurance | <input type="checkbox"/> Advanced injury rehabilitation | <input type="checkbox"/> Increase activity level |
| <input type="checkbox"/> Injury prevention | <input type="checkbox"/> Fun/enjoyment | <input type="checkbox"/> Reduce stress |

Other Goals:

Please identify what you perceive may be barriers for you to achieve your goals (include physical limitations):

