

# Strong Will Performance

## Client Information

Date: \_\_\_\_/\_\_\_\_/20\_\_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: Home (\_\_\_\_) \_\_\_\_\_ Work(\_\_\_\_) \_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_\_

Email Address: \_\_\_\_\_

Which method is best to contact you? \_\_\_\_\_ What is the best time \_\_\_\_\_

Twitter: User ID \_\_\_\_\_ Permission for Text Message: Yes \_\_\_ No \_\_\_

Birth date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_ Address (If not the same): \_\_\_\_\_

How did you hear about Strong Will Performance? \_\_\_\_\_

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## Athletic Information

Team (Pro, School or Association) \_\_\_\_\_ Grade in School: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_

Primary Sport: \_\_\_\_\_

Position in Primary Sport: \_\_\_\_\_

Goals: \_\_\_\_\_

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## Strong Will Performance Information

Are you currently in a training program: \_\_\_\_\_

Have you been referred by a physician? \_\_\_\_\_

What are your reasons for joining Strong Will Performance? \_\_\_\_\_

Goals: \_\_\_\_\_

Current diet regimen: \_\_\_\_\_

STAFF INTAKE WILL MEASURE Height: \_\_\_\_ FT \_\_\_\_ IN Weight: \_\_\_\_\_ LBS

1<sup>st</sup> Review Date: \_\_\_\_/\_\_\_\_/20\_\_\_\_

## Strong Will Performance

### Preparticipation Screening Questionnaire

**Last Name:** \_\_\_\_\_ **First Name:** \_\_\_\_\_ **Birthdate:**    /    /

#### History

**Have had or do you have:**

Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	A heart attack
<input type="checkbox"/>	<input type="checkbox"/>	Heart surgery
<input type="checkbox"/>	<input type="checkbox"/>	Cardiac catheterization
<input type="checkbox"/>	<input type="checkbox"/>	Coronary angioplasty
<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker
<input type="checkbox"/>	<input type="checkbox"/>	Defibrillator/rhythm disturbance
<input type="checkbox"/>	<input type="checkbox"/>	Heart valve disease
<input type="checkbox"/>	<input type="checkbox"/>	Heart failure
<input type="checkbox"/>	<input type="checkbox"/>	Heart transplantation
<input type="checkbox"/>	<input type="checkbox"/>	Congenital heart disease
<input type="checkbox"/>	<input type="checkbox"/>	You have diabetes
<input type="checkbox"/>	<input type="checkbox"/>	You have asthma or other lung disease
<input type="checkbox"/>	<input type="checkbox"/>	You have burning or cramping sensations in your lower legs when walking short distances
<input type="checkbox"/>	<input type="checkbox"/>	You have musculoskeletal problems that limit your physical activity
<input type="checkbox"/>	<input type="checkbox"/>	You have concerns about the safety of exercise
<input type="checkbox"/>	<input type="checkbox"/>	You take prescription medications
<input type="checkbox"/>	<input type="checkbox"/>	You are pregnant

**Has anyone in your immediate family had:**

Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	A heart attack
<input type="checkbox"/>	<input type="checkbox"/>	Heart surgery
<input type="checkbox"/>	<input type="checkbox"/>	Cardiac catheterization
<input type="checkbox"/>	<input type="checkbox"/>	Coronary angioplasty
<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker
<input type="checkbox"/>	<input type="checkbox"/>	Defibrillator/rhythm disturbance
<input type="checkbox"/>	<input type="checkbox"/>	Heart valve disease
<input type="checkbox"/>	<input type="checkbox"/>	Heart failure
<input type="checkbox"/>	<input type="checkbox"/>	Heart transplantation
<input type="checkbox"/>	<input type="checkbox"/>	Congenital heart disease
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes

**If you have answered yes to any of the preceding questions concerning yourself, consult your physical.  
You may need a facility with a medically trained personnel**

#### Symptoms

YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	You experience chest discomfort with exertion
<input type="checkbox"/>	<input type="checkbox"/>	You experience unreasonable breathlessness
<input type="checkbox"/>	<input type="checkbox"/>	You experience dizziness, fainting, or blackouts
<input type="checkbox"/>	<input type="checkbox"/>	You take heart medications

#### Cardiovascular Risk Factors

YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	You are a man older than 45
<input type="checkbox"/>	<input type="checkbox"/>	You are a woman older than 55; have had a hysterectomy, or are postmenopausal

#### Other Cardiovascular Risk Factors

YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	You smoke or quit smoking within the previous 6 months.
<input type="checkbox"/>	<input type="checkbox"/>	You do not know your blood pressure
<input type="checkbox"/>	<input type="checkbox"/>	Your blood pressure is > 140/90
<input type="checkbox"/>	<input type="checkbox"/>	You take blood pressure medication
<input type="checkbox"/>	<input type="checkbox"/>	You are physically inactive (you get < 30 min. of physical activity on at least 3 days per week)
<input type="checkbox"/>	<input type="checkbox"/>	Your blood cholesterol level is > 200
<input type="checkbox"/>	<input type="checkbox"/>	You do not know your cholesterol level
<input type="checkbox"/>	<input type="checkbox"/>	You have a immediate blood relative who had a heart attack or heart surgery before the age of 55 (father or brother) or age 65 (mother or sister)
<input type="checkbox"/>	<input type="checkbox"/>	You are > 20 pounds overweight.

**If you checked one or more of the statements in this section, you will need to consult your physician before beginning any exercise.  
We do strongly feel you will benefit from our highly qualified professional staff, but we want you to do so with all precaution.**

#### Other health issues

<b>Member's Signature</b>		<b>Date</b>	
<b>Parent or Guardians Signature</b>		<b>Date</b>	

# Strong Will Performance

## Informed Consent for Participating in Testing and Training for **Strong Will Performance**

### **Exercise Tests and Training Programs**

I understand that I will be performing a series of physical ability tests to best evaluate balance, running speed, agility, leg power, aerobic power, and body composition. These tests require that I give my complete.

I am completely aware that I will be participating in various high- intensity training sessions to improve body composition, power, strength, agility, and running speed.

### **Risks and Discomforts**

I understand the possibility of injury during training and/or testing exists. Injuries being: but not limited to, muscle sprain, muscle strain, or muscle soreness during or after the testing and/or training periods. Likely is the instance of experiencing a delayed onset of muscle soreness. This soreness is common for athletes beginning an exercise program and has no long-term consequences to my health. In extremely rare cases an athlete can experience abnormal blood pressure, fainting, disorders of the heartbeat, heart attack, stroke and even death. Every effort will be made to minimize the possibilities of these abnormalities by close observation and personal performance evaluation during workouts. Emergency procedures and trained lab personnel are available to handle any unusual situation in the event one arises.

### **Benefit Expectations**

The results obtained from the physical ability testing will support the assessment of my current level of physical ability as it relates to activities for various sports. The results of the testing will also guide Strong Will Performance professional to advocate training to improve my abilities in the areas most needed.

The athlete will improve his or her functional capacity and physical abilities in the basic concepts of sport performance. Improvements in body composition, power, strength, balance and agility, running speed, anaerobic and aerobic power may become evident.

### **Confidentiality – Data and Photographs**

I understand my data may be used, with high level confidentiality, by Strong Will Performance. Data will be entered into a database to serve as a contrast for me and for other athletes of the same age and level of participation. The data collected may also be used in research reports and presentations. With my knowledge and consent, I understand that Strong Will Performance reserves the right to take and make use of photographs for promotional purposes.

### **Inquiries**

Questions about the procedures used in testing and/or exercise training sessions are fully encouraged. Should I have concerns or questions, I do understand the professionals at Strong Will Performance are available to offer in-depth explanations. I also acknowledge that Strong Will Performance trusts all information provided by me about my current physical condition to be true and accurate.

**Refund Policy**

In the event that an athlete cannot complete a program due to medical reasons, a pro-rated refund will be provided. Refunds will be reserved for medical reasons **only** and must be accompanied a written refund request and a detailed letter from the member’s doctor.

**Freedom of Consent**

I have read completely and carefully the preceding information. I understand the test procedures and training protocols I will perform as a member of Strong Will Performance. Permission to perform the tests and/or training is voluntary. **I freely consent to participate voluntarily in all of the prescribed physical ability tests and/or training.** I understand I may stop the individual tests and/or training sessions at any time I feel necessary.

I understand by signing the following, I am assigning consent to be applied to all sections of this consent form.

**Coaches Release**

My data may be released to the following professionals to offer training continuity and guides for optimum performance needs.

Current Athletic Coach \_\_\_\_\_ Phone (\_\_\_\_)\_\_\_\_\_

Athletic Director \_\_\_\_\_ Phone (\_\_\_\_)\_\_\_\_\_

\_\_\_\_\_  
(Printed Name of Participant)

\_\_\_\_\_/\_\_\_\_/20\_\_\_\_\_  
(Signature of Participant) (Date)

\_\_\_\_\_/\_\_\_\_/20\_\_\_\_\_  
(Signature of Parent or Guardian: If the participant is under 18 yrs.) (Date)