

Personal Training Client Intake Form

Non-medical preventative strength and performance services

Client Information

Client Last Name: First Name:

Date of Birth: Age: Pronouns:

Address:

City: State: ZIP:

Client Email: Mobile:

Parent/Guardian Information (required for clients under 18)

Parent/Guardian Name: Relationship:

Email: Mobile:

Emergency Contact

Name: Relationship:

Phone: Alternate Phone:

Training & Gymnastics Information

Gym/Team: Coach(es):

Discipline: ☐ WAG ☐ MAG ☐ T&T ☐ Acro ☐ Other

Current Level: Training hours/week:

Other sports/activities: Years in sport:

Referral & Communication

Who may we thank for this referral?

Preferred communication: ☐ Email ☐ Text ☐ Phone

Health & Exercise Readiness Questionnaire

Complete accurately before beginning training

Important: Personal training is not medical care or physical therapy. This questionnaire helps identify when medical or physical therapy clearance may be appropriate. Report any current pain, injury, change in health, surgery, pregnancy, or medication change before every session.

Readiness Screening - Check Yes or No

- | | | |
|--|------------------------------|-----------------------------|
| 1. Do you currently have pain, an injury, or symptoms that affect exercise or gymnastics? | ☐ Yes | ☐ No |
| 2. Has a physician or other licensed provider ever told you that you have a heart condition or should exercise only under medical supervision? | ☐ Yes | ☐ No |
| 3. Do you experience chest pain, unusual shortness of breath, fainting, or dizziness with activity? | ☐ Yes | ☐ No |
| 4. Do you have uncontrolled high blood pressure, diabetes, seizures, or another condition that may affect exercise safety? | ☐ Yes | ☐ No |
| 5. Have you had surgery, a fracture, concussion, or significant injury within the past 12 months? | ☐ Yes | ☐ No |
| 6. Are you currently pregnant, recently postpartum, or under restrictions related to pregnancy? | ☐ Yes | ☐ No |
| 7. Are you taking medications that may affect heart rate, blood pressure, balance, alertness, bleeding, or exercise tolerance? | ☐ Yes | ☐ No |
| 8. Do you have allergies, skin conditions, bleeding disorders, impaired sensation, or wound-healing concerns? | ☐ Yes | ☐ No |
| 9. Has a healthcare provider advised you to avoid or modify any exercise, skill, loading, impact, or range of motion? | ☐ Yes | ☐ No |
| 10. Is there any other reason you should not participate in exercise today? | ☐ Yes | ☐ No |

Please explain every "Yes" response, including dates, restrictions, and provider recommendations:

Current medications and relevant allergies/precautions:

Training History, Goals & Current Status

Current Status

Are you currently receiving physical therapy or other medical care?

☐ Yes

☐ No

Provider name/practice (if applicable):

Current diagnoses, injuries, precautions, or restrictions:

Date of most recent PT/medical discharge or clearance (if applicable):

Training Goals

Primary goals (check all that apply):

☐ General strength

☐ Core control

☐ Mobility/flexibility

☐ Power/speed

☐ Conditioning

☐ Injury-risk reduction

☐ Return-to-performance conditioning after discharge

☐ Gymnastics-specific movement quality

Top three goals and desired time frames:

1. Time frame:

2. Time frame:

3. Time frame:

Experience & Preferences

Current strength/conditioning program (frequency, duration, key exercises):

Exercises, skills, or equipment you dislike, fear, or prefer to avoid:

Anything else that would help us coach you safely and effectively:

Informed Consent for Personal Training Services

Nature and scope of services. Perfect 10.0 Physical Therapy, PLLC offers non-medical, preventative strength, conditioning, mobility, and gymnastics-performance services delivered by a certified personal trainer. Personal training does not include physical therapy evaluation, diagnosis, treatment, rehabilitation, medical advice, or any service that requires a professional healthcare license.

Role separation. The trainer may work within a physical therapy practice, but is not acting as a physical therapist. The trainer will not diagnose an injury, interpret imaging, change a medical plan of care, perform skilled rehabilitation, or represent training as medically necessary. New pain, injury, neurological symptoms, significant loss of function, or other concerning symptoms will be referred to Dr. Greene or another appropriate licensed healthcare provider before training continues.

Potential Benefits

- Improved strength, power, endurance, mobility, movement quality, confidence, and sport-specific capacity.
- Education regarding exercise technique, training habits, recovery, and injury-risk reduction.
- A structured program that supports performance goals after any required medical or physical therapy clearance.

Material Risks

- Muscle soreness, fatigue, bruising, skin irritation, strains, sprains, falls, aggravation of a prior condition, or other injury.
- Exercise may cause an unexpected medical event, and results cannot be guaranteed.
- Gymnastics and athletic training may involve impact, loading, balance challenges, resistance equipment, and sport-specific movements.

Client Responsibilities

- Provide complete and accurate health information and immediately disclose any new pain, injury, illness, surgery, pregnancy, medication change, or restriction.
- Follow instructions, use equipment appropriately, stop any activity that feels unsafe, and communicate pain or symptoms immediately.
- Obtain medical or physical therapy clearance when requested. The practice may pause or decline training when safety or scope concerns exist.
- Understand that personal training is self-pay and is not billed to health insurance as physical therapy.

Consent & Acknowledgments

- ☐ I have read and understand this form and have had an opportunity to ask questions.
- ☐ I voluntarily consent to participate in personal training and understand the risks, benefits, and alternatives, including choosing not to participate.
- ☐ I understand the difference between personal training and physical therapy and will not rely on the trainer for diagnosis or medical treatment.
- ☐ I authorize emergency medical assistance when reasonably necessary and accept responsibility for related costs.
- ☐ I understand that no specific result or outcome has been promised.

Client/Parent or Guardian Signature:

Date:

Printed Name:

Relationship (if minor):



Practice Policies & Financial Agreement

Scheduling, Payment & Cancellation

- ☐ Full payment is due according to the practice's current booking and payment procedures. Personal training services are self-pay and are not submitted to insurance as physical therapy.
- ☐ At least 24 hours' notice is required to cancel or reschedule. Late cancellations and no-shows may be charged the full scheduled service fee, consistent with the practice's posted policy.
- ☐ Arriving late may shorten the session without reducing the fee. The trainer cannot extend a session when another client is scheduled.
- ☐ Fees, service descriptions, and add-on prices may change with advance notice. Any optional add-on must be selected and paid through the practice; clients should not pay the trainer directly.
- ☐ A valid payment method may be required to remain on file. Declined payments, chargebacks, or unpaid balances may pause future scheduling.

Communication & Privacy

By providing contact information or initiating communication by email or text, you authorize the practice to contact you for scheduling, billing, program updates, and service-related questions. Standard email and text messaging may not be secure. Please limit sensitive information and use the practice's secure systems when available.

Because these services occur within a healthcare practice, personal and health-related information may be maintained in the practice record and accessed only by authorized personnel for operations, safety, payment, and coordination of services. The practice's Notice of Privacy Practices remains available upon request.

Conduct, Safety & Scope

- A parent/guardian must complete and sign required forms for a minor. Practice and gym safety rules apply at all times.
- The practice may end or pause a session for unsafe conduct, undisclosed health concerns, inappropriate behavior, or services outside the trainer's role.
- The trainer may communicate with Dr. Greene regarding safety, scope, readiness, and program coordination. Clinical decisions remain with licensed healthcare providers.

Acknowledgment

- ☐ I have read, understand, and agree to the Practice Policies and Financial Agreement.

Client/Parent or Guardian Signature: Date:

Printed Name: Relationship (if minor):

Credit Card Information & Payment Authorization

Complete this section for the payment method authorized to remain on file.

Cardholder Information

Cardholder Name

Relationship to Client

Card Type

☐

Visa

☐

Mastercard

☐

American Express

☐

Discover

Card Number

Expiration (MM/YY)

CVV / Security Code

Billing ZIP

Billing Address

Street Address

City

State

ZIP

Payment Authorization

I authorize Perfect 10.0 Physical Therapy, PLLC to keep the payment method listed above on file and charge it for amounts I authorize or owe under the Practice Policies & Financial Agreement, including scheduled services, applicable late-cancellation or no-show fees, and unpaid balances. I understand that I am responsible for keeping my payment information current and may provide a replacement payment method to the practice.

Cardholder Signature

Date

Printed Name

Relationship (if not client)

For practice use: Handle payment card information only through approved secure systems and according to practice policy.

Authorization for Information Sharing & Coordination

This optional authorization allows Perfect 10.0 Physical Therapy, PLLC to communicate with the people you select regarding personal training participation, restrictions, scheduling, progress, and coordination. You may limit the information shared and may revoke this authorization in writing, except to the extent action has already been taken in reliance on it.

Client Information

Client Name: Date of Birth:

Authorized Recipients

1. Name/Organization: Phone/Email:
Relationship/Role: Coach ☐ Parent ☐ Provider ☐
2. Name/Organization: Phone/Email:
Relationship/Role: Coach ☐ Parent ☐ Provider ☐
3. Name/Organization: Phone/Email:
Relationship/Role: Coach ☐ Parent ☐ Provider ☐

Information That May Be Shared

- ☐ Attendance and scheduling ☐ Training goals and program overview
☐ Performance observations and progress ☐ Restrictions, precautions, and safety concerns
☐ Relevant PT/medical information already authorized for coordination ☐ Other (describe below)

Expiration & Signature

This authorization expires on: (or one year after signature if left blank)

I understand that information disclosed to a non-healthcare recipient may no longer be protected by HIPAA. Signing this authorization is voluntary and is not a condition of receiving services, except when communication is necessary to safely coordinate a requested service.

Client/Parent or Guardian Signature: Date:

Printed Name:

Photo & Video Authorization

Clinical/internal use is separate from optional public marketing

Part A - Internal Training Documentation

Photographs or video may be useful for exercise technique review, movement comparison, program planning, progress tracking, and internal staff education. Any internally retained media will be handled as confidential practice information and accessed only by authorized personnel.

- ☐ YES, I consent to internal training documentation.
- ☐ NO, I do not consent to internal training documentation.

Part B - Optional Marketing & Public Use

I authorize Perfect 10.0 Physical Therapy, PLLC to use selected photographs or videos for the practice website, social media, educational/promotional materials, community outreach, or professional presentations. Public media may include identifiable features. Declining Part B will not affect access to services. This authorization may be revoked prospectively in writing, but previously published or distributed material may not be fully retrievable.

- ☐ YES, I consent to optional marketing and public use.
- ☐ NO, I do not consent to marketing or public use.

Optional limitations (no face, no name, specific platforms, etc.):

Client/Guardian Authorization

Client Name:

Parent/Guardian Name (if minor):

Client/Parent or Guardian Signature:

Date:

Printed Name:

Final Client Certification & Trainer Review

Client Certification

By signing below, I certify that the information provided in this packet is complete and accurate to the best of my knowledge. I agree to update the practice promptly when information changes. I understand that omission or misrepresentation may increase risk and may result in suspension of services.

- ☐ I completed the Client Intake Form and Health & Exercise Readiness Questionnaire.
- ☐ I reviewed and signed the Informed Consent for Personal Training Services.
- ☐ I reviewed and signed the Practice Policies & Financial Agreement.
- ☐ I completed the cupping consent only if I wish to request that optional service.
- ☐ I understand that the trainer is not providing physical therapy or medical treatment.

Client/Parent or Guardian Signature:

Date:

Printed Name:

Relationship (if minor):

Trainer/Practice Review - Staff Use Only

Packet reviewed by:

Date:

Clear to begin personal training?

☐ Yes☐ No☐ With conditions

PT/medical clearance required?

☐ Yes☐ No

Cupping eligibility confirmed?

☐ Yes☐ No☐ N/A

Conditions, precautions, referrals, or follow-up needed:

Trainer signature/initials:

Date: