

Name: _____ D.O.B: _____

Address: _____

Phone: _____ Email: _____

Emergency Contact: _____ Phone: _____

Would you like to be on my Essentrics® mailing list? (I will not share your information with anyone): Yes ___ No ___

I may occasionally have a camera in class. Would you be OK to have your photo used in future marketing efforts? Yes ___ No ___

What is your goal in practicing Essentrics®:

- | | | |
|---|--|--|
| <input type="checkbox"/> Stress reduction | <input type="checkbox"/> Overall sense of well-being | <input type="checkbox"/> Increased endurance |
| <input type="checkbox"/> Improved Flexibility | <input type="checkbox"/> Weight management | <input type="checkbox"/> Injury prevention |
| <input type="checkbox"/> Increased Strength | <input type="checkbox"/> Pain management | <input type="checkbox"/> Other _____ |

Are you currently experiencing any of the following medical conditions? (check & circle)

- | | |
|--|---|
| <input type="checkbox"/> High/ Low Blood Pressure | <input type="checkbox"/> Digestive / Urinary Problems |
| <input type="checkbox"/> Respiratory / Circulatory Problems | <input type="checkbox"/> Muscular / Tendon / Joint Injury or Pain |
| <input type="checkbox"/> Neck / Back / Spine Injury | <input type="checkbox"/> Vision / Hearing Loss |
| <input type="checkbox"/> Dizzy spells / Fainting / Epilepsy / Seizures | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Menopause / Pregnancy | <input type="checkbox"/> Depression, Anxiety / PTSD |
| <input type="checkbox"/> Headaches / Chronic Pain / Fatigue | Details and / or Other: _____ |

List or describe all other medical conditions, physical limitations, surgeries, health concerns and medications that you are currently using and the reason for taking them: _____

Release and Waiver (REQUIRED)-THIS AGREEMENT AFFECTS YOUR LEGAL RIGHTS. READ IT CAREFULLY!

Please consult your physician prior to starting an exercise or fitness program. To the best of your knowledge you are in good physical and mental condition and capable of participating in this Essentrics® class. You are not aware of any physical or mental illness or injury that prevents you from participating in Essentrics®. (Initials)

You, the client, are aware that there are risks associated with participating in Essentrics®. Your participation is completely voluntary, and you freely accept and fully assume all responsibility for all risks, and all possibilities of personal injury, death, property damage or loss to yourself or any other person as a result of your participation in Essentrics®. You and your heirs, next of kin, executors, administrators and assigns agree: (a) to waive all claims, known or unknown, that you have or may have in the future against Lynne Loiselle and the hosting facility, including their owners, officers, directors, agents, employees, volunteers, business operators, independent contractors and site property owners or lessees;(b) that Lynne Loiselle is not liable or responsible for any damage to, loss or theft of your property; (c) to release and forever discharge Lynne Loiselle from all liability for any personal injury, death, property damage or loss resulting from your participation in Essentrics® classes due to any cause, including but not limited to negligence (failure to use such care as a reasonably prudent and careful person would use under similar circumstances), breach of any duty imposed by law, breach of contract or mistake in error of judgment of Lynne Loiselle; and (d) to be liable for and to hold harmless and indemnify Lynne Loiselle from all actions, proceedings, claims, damages, costs demands, including court costs on a solicitor and own client basis, and liabilities of whatsoever nature or kind arising out of or in any way connected with your participation in Essentrics® classes.

Signature

Date