LIABILITY WAIVER

Please read the following questions carefully and answer by circling YES or NO.

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 balance because of dizziness or do you ever lose consciousness?
YES NO Do you have a bone or joint problem that could be made worse by a change in your physical activity?
YES NO Is your doctor currently prescribing medications for blood pressure or a heart condition?
YES NO Has your doctor ever said that you have a heart condition and that you should only do restrictive physical activity.
YES NO Do you know of any other reason why you should not do physical activity?(If YES,Need Physicians Clearance Before Program)

I assume the risk in participation in fitness activity and further agree to release and forever discharge Massage Chi Holistic and Fitness Center, its affiliates, staff and instructors from any and all claim that may result from my injury, death, accidental or otherwise, during or arising in any way from any exercise participation. **CLIENT INITIAL ____**

I understand that certain risks may be involved in any exercise program. These risks may include musculoskeletal pain, soreness, spinal injuries, elevated heart rate, labored breathing, excessive sweating or light-headedness. I understand that every effort will be made to minimize these risks. I understand the risks and declare myself physically sound and/or have medical approval to participate in any exercise. **CLIENT INITIAL ____**

I agree to observe and obey all posted rules and warnings, and further agree to follow any oral instructions or directions given by Massge Chi Holistic and Fitness Center staff. **CLIENT INITIAL ____**

I will take personal responsibility to report to my trainer/instructor any new diagnosis, injuries or surgical procedures occurring during my contact that could affect my fitness training. I will take personal responsibility for reporting any unusual signs/symptoms to my trainer/instructor. I understand that if I have indicated positive to any medical history questions, a medical referral may be necessary. Any information that is obtained regarding my fitness training and my progress will be confidential and will not be released or revealed to any person other than my physician without my expressed or written consent. **CLIENT INITIAL ____**

Signature: _____ Date:_____

Print Name: _____

Massage Chi Staff Signature: _____