

# Full-Fill Your Life Retreat 2011

Name: \_\_\_\_\_

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

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

Phone: \_\_\_\_\_

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

## **Retreat Tuition:** \$2950.00 (includes the following)

- 5 Nights / 6 days luxurious hotel accommodations.
- 5 Chef prepared meals daily.
- Bottled water.
- 4 hours of workout daily, one on one training or guided group sessions.
- Daily individual sessions with our Psychotherapist.
- 1 Deep tissue massage
- Personalized workout program and eating plan to take home.
- Personal journal to track your progress

## **Registration Policy:**

- \$650.00 minimum down payment (\$450.00 Non-refundable/non-transferable) due upon registration. If paying by credit card, any balance due will be charged to credit card on file. If paying by check, make payable to: Bud's Total Body Boot Camp.
- Balance of retreat fees are due 4 weeks prior to the first day of the retreat.

## **Cancellation Policy:**

- Cancellations must be made in writing. Via fax, email or USPS.
- You will receive a full refund minus the \$450.00 non-refundable/non-transferable administration fee.
- Cancellations received less than 4 weeks prior to the retreat may be transferred to next space available on any future retreat.

I hereby confirm that I have read and understand the registration and cancellation policies and agree to the terms above. Agreement to these policies will apply to this and any future retreat registrations, unless revised by Bud's Total Body Boot Camp and it's Associates. If I am paying by credit card, I authorize Bud's Total Body Boot Camp to charge all fees to my credit card for the retreat.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Return form to:

Bud's Total Body Boot Camp

2265 Lee RD. Suite 201

Winter Park, Fl. 32789

Fax to: 407-599-9337

[www.buds-ultimate-fitness.com](http://www.buds-ultimate-fitness.com)



## Application

Name: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_  
State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Ph. Home: \_\_\_\_\_ Cell: \_\_\_\_\_ Wk.: \_\_\_\_\_  
E-mail: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Sex: \_\_\_\_\_

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| <b>Heath History</b> |
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**Have you had or do you have: (check all that apply)**

- |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Rheumatic fever<br><input type="checkbox"/> Thrombophlebitis<br><input type="checkbox"/> Angina / Chest pain<br><input type="checkbox"/> High Cholesterol<br><input type="checkbox"/> Abnormal Electrocardiogram<br><input type="checkbox"/> Fixed rate pacemaker<br><input type="checkbox"/> Heart Medications<br><input type="checkbox"/> Irregular Heart Beat<br><input type="checkbox"/> High Blood Pressure<br><input type="checkbox"/> Respiratory Infections<br><input type="checkbox"/> Diabetes<br><input type="checkbox"/> Varicose Veins | <input type="checkbox"/> Heart Attack<br><input type="checkbox"/> Heart Murmur<br><input type="checkbox"/> Asthma<br><input type="checkbox"/> Disease of Arteries<br><input type="checkbox"/> Embolism<br><input type="checkbox"/> Stroke<br><input type="checkbox"/> Valve Disease<br><input type="checkbox"/> Rapid Heart Beat<br><input type="checkbox"/> Low Blood Pressure<br><input type="checkbox"/> Aneurysm<br><input type="checkbox"/> Anemia<br><input type="checkbox"/> Epilepsy |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

**Has your Physician ever advised you against exercise?**

Yes \_\_\_\_\_ No \_\_\_\_\_ If yes,

Why? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Do you have any of the following conditions that may limit your physical activity?  
(Check all that apply)**

- |                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                    |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Arthritis<br><input type="checkbox"/> Shoulder / clavicle injury<br><input type="checkbox"/> Arm / elbow injury<br><input type="checkbox"/> Calcium deposits<br><input type="checkbox"/> Upper back injury<br><input type="checkbox"/> Bone fracture<br><input type="checkbox"/> Hip / pelvic injury<br><input type="checkbox"/> Other, please | <input type="checkbox"/> Ankle / foot injury<br><input type="checkbox"/> Low back pain<br><input type="checkbox"/> Knee thigh injury<br><input type="checkbox"/> Nerve damage<br><input type="checkbox"/> Head /neck injury<br><input type="checkbox"/> Wrist hand injury<br><input type="checkbox"/> Tennis elbow |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

Explain \_\_\_\_\_  
\_\_\_\_\_

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**Are you presently receiving physical therapy?**

☐ Yes ☐ NO

**Have you or any of your relatives had one of the following? (Check all that apply)**

☐ Heart disease

☐ Diabetes Mellitus

☐ Heart operations

☐ Stroke

☐ Congenital heart disease

☐ High blood pressure

If yes, note relationship and age:

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**Are you presently taking any medications?**

☐ Yes ☐ No If yes, please list names and dosages:

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**What was your weight one year ago? \_\_\_\_\_**

**Five years ago? \_\_\_\_\_ At age 21? \_\_\_\_\_**

**Are you currently on a weight loss and / or exercise program?**

☐ Yes ☐ No

If yes, please describe:

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**List all weight loss and / or exercise programs you have tried.**

A \_\_\_\_\_

B \_\_\_\_\_

C \_\_\_\_\_

**Did you lose weight? ☐ Yes ☐ No**

**If yes, how much? \_\_\_\_\_**

**How long did it take to lose that much weight? \_\_\_\_\_**

**How long did you maintain the weight loss? \_\_\_\_\_**

**Why do you think it failed? \_\_\_\_\_**

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**Do you smoke?** ☐ Yes ☐ No

**If yes, how much per day?** \_\_\_\_\_

**When did you start smoking?** \_\_\_\_\_ **If you stopped, when?** \_\_\_\_\_

**Do you use recreational drugs?** \_\_\_\_\_

**If yes, what and how much per day?** \_\_\_\_\_

**When exercising, including climbing stairs, do you ever experience any of the following? (Check all that apply)**

☐ Chest pains

☐ Pressure over the heart

☐ Leg aches

☐ Shortness of breath

☐ A tired out feeling

☐ Dizziness

**How would you rate the stress level of your job?**

☐ Very little ☐ Moderate ☐ Stressful

**Have you ever had a stress test?** ☐ Yes ☐ NO

**Have you ever consider surgery for weight loss?** ☐ Yes ☐ No

If yes, please describe:

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**Do you have any food allergies or restrictions?** \_\_\_\_\_

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| <b>Mental Health</b> |
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**What do you think are the psychological reasons you are overweight?**

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**Have you had previous psychotherapy? If so, with whom?**

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**What did you learn about yourself?**

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**What did you change about your life?**

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**What motivates you?**

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**What discourages you?**

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**During this Retreat what changes do you plan to make?**

**Regarding you:**

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**In relation to others:**

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**In relation to health:**

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**Tell us why you think you are attending this Retreat.**

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**Consent to participate:**

I understand that I have voluntarily applied for the Full Fill your life Retreat. If I am chosen I agree to participate in daily psychotherapy sessions; workout 4 hours per day. I agree to maintain both a written journal. I understand that portions of my journals may be used and I am may be filmed for future advertisements. I agree to all the terms and conditions.

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Retreat client name in print

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Retreat client signature

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Date