PFC • Performance Fitness Concepts

Your Ultimate Resource for Optimum Health

Premium Supplements • Metabolic Nutrition • Fitness Training

WELCOME TO PFC!

In our 20 years of designing individual nutrition programs, people say that no one knows nutrition like PFC! The mystery lies in the combination of foods - it's different for everyone. The solution: **metabolic nutrition**. The experts at PFC know metabolic nutrition and metabolic typing. By identifying how your body uses food for energy, we unlock the secret combination of foods that work most efficiently for you, whatever your health goals.

Many people don't realize that nutrition impacts whatever you do, each minute of every day. Ultimately, nutrition provides the fuel that determines what you can and cannot do – your mental and physical performance. That's why metabolic nutrition lies at the core of our program. Our nutritionists take a look at your lifestyle, stress levels, and health history, plus evaluate your lipid profile in order to get to know what's right for you. Your nutrition program is truly individualized, based on how efficiently your body uses different foods for energy.

Nutrition is just part of the puzzle. For optimum health, your body needs exercise, too. Did you know that the combination of exercise for attaining ultimate fitness in the least amount of time also depends upon your metabolic type? Some people get results devoting more time to cardiovascular conditioning while others should focus on weight training.

PFC provides the education you need to optimize your health. With this information, you can take charge of your health, nutrition, fitness, and mental well-being. Anyone who works with us knows about our commitment to guiding each client towards optimum health through personalized nutrition, supplementation, and exercise programs.

Optimize your health! Access the combined knowledge of our nutrition and fitness staff.

Why integrate PFC programs into your life?

- Lose body fat.
- Build strength and preserve lean muscle.
- Reduce "bad" cholesterol (LDL) levels.
- Minimize risk of cardiovascular and many other diseases.
- Stabilize blood sugar.
- Enhance mental acuity.
- Maintain high energy levels.
- Boost immunity.
- Optimize health!

SERVICES

NUTRITION

- ✓ Personalized Nutrition Programs
- ✓ Metabolic Assessment
- ✓ Total Cholesterol and Full Lipid Profile
- ✓ Glucose Testing
- ✓ Body Composition Testing

EXERCISE

- ✓ Personalized Exercise Programs
- ✓ Exercise Testing and Fitness Evaluation
- ✓ Certified Personal Training

  Including:

  Multi-Angular Training
  Stability Training
  Cardio Vascular Training
  Exercise Specific Training
  Rehabilitation Training

BENEFITS

After an extensive survey of our clients, 95% reported that Fitness Concepts' programs exceeded their expectations and that their money was well spent. Listed below are some of the major benefits our clients have received as a result of our programs

- Increased energy
- Greater productivity in the workplace
- Consistent energy levels throughout the day
- Increased clarity and effectiveness
- Reduction in employee sick days
- Decrease health risk
- Increased metabolic efficiency
- Elimination of sugar cravings
- Loss of body fat
- Increase muscle mass
- Improved Posture
- Increased self-esteem and self-worth

Our programs also impact individual's medical conditions such as:

- Diabetes
- Hypoglycemia
- High Cholesterol
- Heart Disease
- IBS
- …and many more

HOW OUR PROGRAM IS STRUCTURED

INITIAL VISIT (1 hour) $695.00

- Blood lipids and glucose tested and evaluated
- Family health history evaluated
- Personal health history evaluated
- Height, weight, lean muscle mass and body fat percentage determined
- Current medical and fitness condition evaluated
- Blood pressure assessment
- Lifestyle evaluated
- Personal fitness and nutrition goals established

SECOND VISIT (1 hour) $420.00

- Personalized nutrition and exercise program presented and explained
- Clients to keep track of their foods including: food intake, eating times, energy levels, sleep patterns, digestion, etc.
- Based on report of finding from the initial visit, individualized stretching and rehabilitative program developed.

WEEKLY FOLLOW UP VISITS (1/2 hour)* $110.00

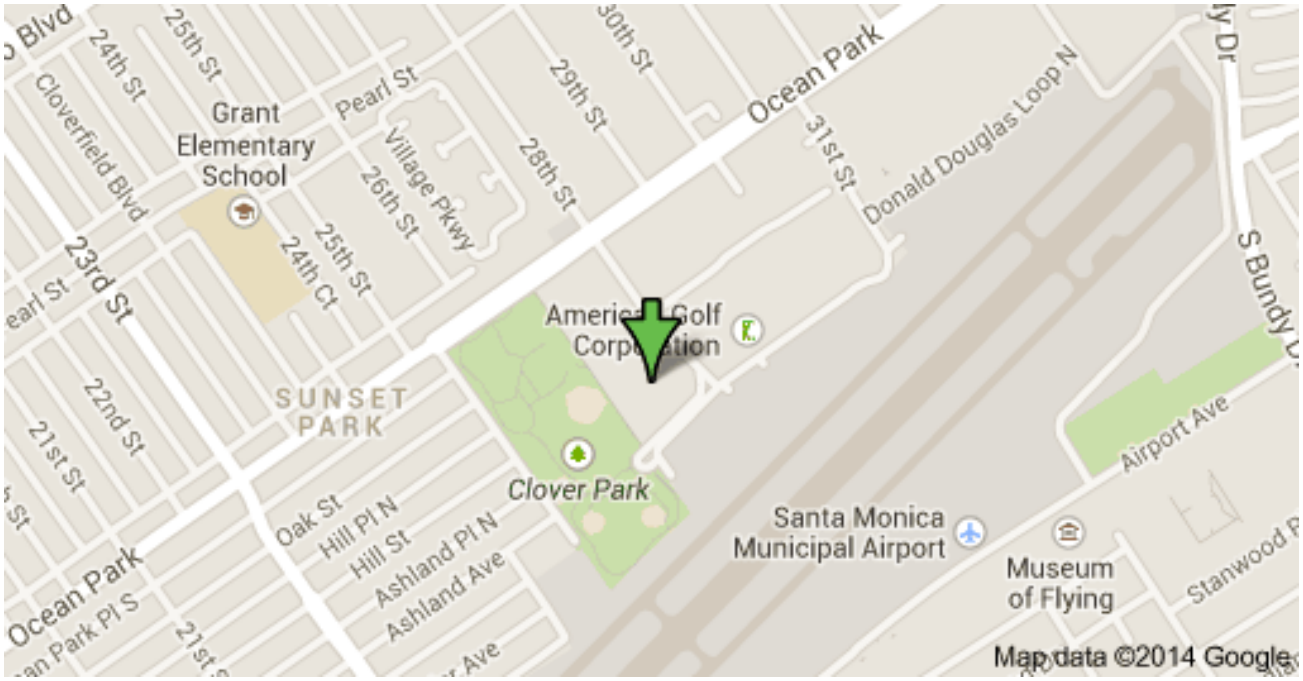
- Weight and body fat percentage taken
- Weekly food intake and energy levels evaluated
- Foods adjusted as metabolic efficiency and body composition change
- On-going coaching provided based on how you "communicate" with food in your life

Exercise programs and training protocols modified as overall wellness improves

*Lipid profile additional when applicable **$45.00**

Signature_____ Date_____

2800 28th St. Suite 130., Santa Monica, ca. 90405



- Fitness Concepts is located at the end of 28th St on the right side in the all glass black building.

- WE ARE NOT IN THE VW/AUDI BUILDING at the end of 28th ST.

PATIENT AND FAMILY HEALTH HISTORY

CHECK THE CONDITIONS LISTED BELOW FOR YOURSELF OR ANY BLOOD RELATIVE	SELF	FATHER	MOTHER	SISTER/BROTHER	SON	DAUGHTER	CHECK THE CONDITIONS THAT APPLY	SELF	FATHER	MOTHER	SISTER/BROTHER	SON	DAUGHTER
ALCHOHOLISM							LIVER DISEASE						
ALLERGIES							MENOPAUSE						
ANGINA							NERVOUS BREAKDOWN						
ANEMIA							POLIO						
ARTHRITIS							PHLEBITIS						
ASTHMA							RECTAL TROUBLE						
BLINDNESS (EITHER EYE)							RECURRENT BOLLS						
BIRTH DEFECTS							RHEUMATISM						
BLEEDING TENDENCY							RHEUMATIC FEVER						
BROKEN BONES							SERIOUS DEPRESSION						
CANCER							SERIOUS EMOTIONAL PROBLEMS						
CHRONIC BRONCHITIS							SKIN DISEASE						
COLITIS							SICKLE CELL ANEMIA						
COLON OR BOWEL TROUBLE							STOMACH ULCER						
DEAFNESS							STROKE						
DIABETES							SUICIDE						
EAR INFECTIONS							SYPHILLIS						
EMPHYSEMA							THYROID (OVERACTIVE)						
ENLARGED HEART							THYROID (UNDERACTIVE)						
EPILEPSY							TUBERCULOSIS						
GALL STONES							VARICOSE VEINS						
GLAUCOMA							**MEN ONLY**						
GOITER							PROSTATE PROBLEMS						
GOUT							**FEMALE ONLY**						
HAY FEVER							MENSTRUAL PROBLEMS						
HEART ATTACK							CYSTITIS						
HEART DISEASE							MASTITIS						
HEART MURMUR AS ADULT							OVARIAN CYST						
HEMORROIDS							BREAST CANCER						
HEPATITIS							OTHER BREAST DISEASE*						
HIGH BLOOD PRESSURE							OTHER GYNOCOLOGICAL PROBLEM*						
H.I.V							STILL MENSTRUATING						
LOW BLOOD PRESSURE							AGE PERIODS STARTED						
HYSTERECTOMY							AGE PERIODS STOPPED						
KIDNEY DISEASE							WHY PERIODS STOPPED						
KIDNEY INFECTION							NUMBER OF PREGNANCIES						
KIDNEY STONES							NUMBER OF CHILDREN						
LEUKEMIA							NUMBER OF MISCARRIAGES						
OBESITY							*EXPLAIN						

PATIENT AND FAMILY HEALTH HISTORY

OPERATIONS	YES	NO	DATE
TONSILITIS			
APPENDIX			
GALL BLADDER			
STOMACH			
SMALL INTESTINE			
KIDNEY			
COLON			
THYROID			
HERNIA			
BREAST (WOMEN)			
UTERUS			
OVARIES			
PROSTATE (MEN)			
OTHER			
X-RAYS			
BACK			
CHEST			
COLON			
EXTREMETIES			
KIDNEY			
STOMACH			
TREATMENTS:			
MEDICATIONS			
INSULIN			
CORTISONE			
THYROID MEDICINE			
BLOOD PRESSURE			
TRANQUILIZERS			
SEDATIVES			
HORMONES			
BIRTH CONTROL			
VALIUM			
PROZAC			
DIGITALIS			
OTHER:			
DO YOU SMOKE?			
DRINK COFFEE?			
DRINK BEER?			
DRINK HARD LIQUOR?			
HAVE YOU BEEN HOSPITALIZED?			
IF YES: WHY?			

IMMUNIZATION	YES	NO	DATE
SMALL POX			
TETANUS			
POLIO SHOTS			
POLIO ORAL			
MEASLES			
INFLUENZA			
GERMAN MEASLES			
OTHER:			
DEVICES			
EYE GLASSES			
CONTACT LENSES			
HEARING AID			
DENTURES			
NECK BRACE			
BACK BRACE			
OTHER BRACE			
ARTIFICAL LIMB			
ARTIFICIAL EYE			
TRUSS			
PACEMAKER			
I.U.D.			
DIAPHRAM			
ORTHOPEDIC APPLIANCE			
OTHER:			
ALLERGIES			
PENICILLIN			
SULFA			
ASPRIN			
BUFFERIN			
FOODS			
DUST			
FABRIC			
METALS			
VITAMINS			
NAIL POLISH			
COSMETICS			
LOTIONS			
OTHER:			

PATIENT AND FAMILY HEALTH HISTORY

GENERAL			NECK					
	YES	NO		YES	NO			
FREQUENTLY ILL			STIFFNESS					
FEVER			SWELLING					
CHILLS			LUMPS					
BRUISE EASILY			OTHER:					
SWOLLEN GLANDS			**GASTRO-INTESTINAL**					
LOSS OF MEMORY			APPETITE POOR					
GENERAL WEAKNESS			INDIGESTION/HEARTBURN					
ACHES/PAINS			NAUSEA					
HEAD			VOMITING BLOOD					
DOUBLE VISION			ABDOMINAL PAIN OR CRAMPS					
LIGHT FLASHES			ABDOMINAL TENSION					
BLURRED VISION			DIARRHEA					
HALOS AROUND EYES			CONSTIPATION					
EYE PAIN			BOWEL HABIT CHANGES					
EAR PAIN			BLACK TAR BOWEL MOVEMENT					
BUZZING/RINGING IN EARS			CONSTANT STOMACH TROUBLE					
EAR DRAINING			**KIDNEY**					
NOSE BLEEDS			UP NIGHTS TO URINATE			**MALE**		
SINUS PROBLEMS			BLOOD IN URINE			LUMP IN TESTICLES		
DEAFNESS			PROBLEM PASSING URINE			PENIS DISCHARGE		
MOUTH, TOOTH PROBLEMS			BURNING PAIN WHILE URINATING			BREAST LUMP		
PERSISTANT HOARSENESS			TROUBLE CONTROLLING URINE			SORE ON PENIS		
OPEN SORES			OTHER:			ERECTION DIFFICULTIES		
SKIN			**NEUROMUSCULATURE**			OTHER:		
RASH			LEG OR ARM WEAKNESS			**FEMALE**		
CHANGING MOLES			BALANCE PROBLEMS			BREAST LUMP		
PIGMENTATION			DIZZINESS			NIPPLE DISCHARGE		
OTHER SKIN PROBLEMS			FAINTING SPELLS			VAGINAL DISCHARGE		
CHEST-HEART LUNGS			SPEECH PROBLEMS			NON-PERIOD BLEEDING		
IRREGULAR HEARTBEAT			OTHER:			HOT FLASHES		
SHORTNESS OF BREATH			**BONES-JOINTS**			PAIN WITH INTERCOURSE		
LOW EXERCISE TOLERANCE			JOINT PAIN			PAIN OTHER THAN WITH PERIODS		
HEART FAILURE			JOINT SWELLING			CHANGE IN PERIODS		
CHEST PAINS			MUSCLE STRENGH LOSS			POSSIBLY PREGNANT		
FREQUENT COUGHS			MUSCLE LUMP OR SWELLING			OTHER:		
COUGH UP BLOOD			LUMP ON BONE					
WHEEZING			PAIN IN BACK					
NIGHT SWEATS			OTHER:					
SWOLLEN ANKLES			**ENDOCRINE**					
CRAMPS IN LEGS			CONSTANT THIRST					
OVER WEIGHT			MOST ALWAYS COLD					
BOTHERED BY THUMPING HEART			TOO WARM MOST TIMES					
OTHER:			VERY SLUGGISH OR TIRED					

Liability Waiver

In consideration of being allowed to participate in the activities and programs at Performance Fitness Concepts Inc. and use it's facilities, equipment, and machinery in addition to the payment of any fee or charge, I do hereby waive, release, and forever discharge performance Fitness Concepts Inc. and it's officers, agents, employees, trainers, representatives, nutritionists, executors and all others from any and all responsibilities or liability from injuries or damages resulting from my participation in any activities or my use of equipment or machinery in the above mentioned activities. I do also hereby release all of those mentioned and any others acting upon their behalf from any responsibility or liability for any injury or damage to myself, including those caused by negligent act or omission or connected with my participation at the gym I am training.
(Please initial_____)

I understand and am aware that strength, flexibility, and aerobic exercise, including the use of equipment, are potentially harmful activities. I also understand that fitness activities involve a risk of injury or even death, and I am voluntarily participating in these activities and using equipment and machinery with knowledge of the dangers involved. I hereby agree to expressly assume and accept any and all risks of injury or death, which may result from such activity.
(Please initial_____)

I do hereby declare myself to be physically sound suffering from no condition, impairment, disease, infirmity or other illness that would prevent my participation or use of equipment or machinery except as hereinafter stated. I do hereby acknowledge that I have been informed of the advisability for a physician's approval for my participation in an exercise/fitness activity, or in use of exercise equipment and more frequent physical examination and consultation with my physician to physical activity, exercise and use of exercise and training equipment so that I might have his or her recommendations concerning these fitness activities and equipment use. I acknowledge that I have either had a physical examination and been given my physician's permission to participate, or that I have decided to participate in an activity and use of equipment and machinery without the approval of my physician and do hereby assume all responsibility for my participation and activities, and utilization of equipment in my activities.
(Please initial_____)

_____ _____
Signature **Date**

NUTRITION AND TRAINING CANCELLATION POLICY

Dear Clients:

Please note that the notification policy for cancellation of nutrition and/or training appointments must be given 24 hours prior to an appointment. If no notice is given, the client will be charged the full amount of the session. Office hours are 9am to 6pm Monday through Friday.

Payment made towards training is nonrefundable. All training must be completed six months from the date of purchase or it is forfeited. In the event training is temporarily or permanently stopped due to a medical condition, these payments may be used toward nutritional consultations or supplements.

In addition, in order to expedite the accounting and billing process for the sale and service of products, we are requesting that a credit card number be kept in a secured on-line vault for your convenience.

Thank you for your cooperation.

NAME OF CARD HOLDER: _____

SIGNATURE ON FILE: _____

Doctor Notification Policy:

It is common practice for naturopaths, nutritionists, and other non-licensed practitioners to collect your signature on a liability waiver form such as this. By doing so you acknowledge that it is your responsibility to deliver all laboratory test results, now and in the future, to your own physician for any *medical* interpretation or opinion regarding any laboratory results provided by Philip Goglia or his affiliates. The undersigned agrees that he or she will receive *a nutritional interpretation* of the test results from Philip Goglia that is to be used exclusively by the undersigned as an educational tool for personal health purposes. However, the personal physician of the undersigned may use these same laboratory results to diagnose and treat disease. The information on Philip Goglia's web sites, brochures, flyers, and information packets are believed to be extremely accurate, but such accuracy cannot be guaranteed by Philip Goglia or his independent representatives, associates and affiliates as we are not the originators of the underlying data used in the interpretation. The undersigned releases Philip Goglia from any liability for injury or loss arising out of the use of, or reliance on, the laboratory results and/or the dietary, supplement and lifestyle suggestions provided. Before making any changes to the exercise, diet or nutritional or hormonal supplementation of the undersigned, a physician should be consulted.

Philip Goglia does not diagnose, cure or treat any illness or disease. *Out of reference laboratory reference range results* will be indicated on the official lab result form, provided by Philip Goglia from a State Certified Laboratory to the undersigned. This information is not intended to, cannot, and should not be expected to substitute for a personal consultation with your own physician. Further, the undersigned releases Philip Goglia , his lab partners, his independent representatives, associates and affiliates from any and all liability for any failure to identify any medical condition or disease. It is understood and agreed that this is not the purpose of their services.

Refund policy:

If you make a mistake collecting saliva or urine specimens, etc., or if the lab refuses to accept specimens because of a mistake you made, a free replacement test kit will be provided to you. Please call the office before discarding any specimens collected. Otherwise, once test kits are in your possession, they may not be returned and no refunds are allowed for any test kits due to safety, hygiene and accuracy concerns.

_____ _____

Signature Date

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Your Ultimate Resource for Optimum Health

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PATIENT

Name: _____ Home Phone: ( ) _____

Address: _____ Business Phone: ( ) _____

City: _____ Mobile Phone: ( ) _____

State: _____ Drivers License: _____

Zip: _____ Birthdate: _____

Email Address: _____

Referred by: _____

EMPLOYMENT

Occupation: _____

Employed by: _____

Employer Address: _____

_____

Employer Phone: ( ) _____

Circle the highest Year completed in School

Elementary **1 2 3 4 5 6 7 8**

High School **1 2 3 4**

College **1 2 3 4**

SPOUSE

Spouse Name: _____

Spouse Employer: _____

Employer Phone: ( ) _____

Marital status

Single Married Widow Divorced

Emergency Contact

Name: _____

Home Phone: _____

Work Phone: _____

Relationship: _____