Personal Training Data Sheet

Name: ____
Last *First* *Middle*

Date of Birth: ____________________ Age: ________________
Month *Day* *Year*

Address: ____
Street *City* *State* *Zip Code*

Contact Number (best): _________________________________ (Business/Home/Cell/Work)

Contact Number (alternative)_________________________________ (Business/Home/Cell/Work)

Email: ____ ❏ Male ❏ Female

In case of emergency, please contact:

Name: ____ Relationship: _______________

Address: ____

Phone: ____

Physical Activity Readiness Questionnaire (PAR-Q)

Regular exercise is associated with many health benefits. Increasing physical activity is safe for most people. However, some individuals should check with their physician before they become more physically active. Completion of this questionnaire is a first step when planning to increase the amount of physical activity in your life. Please read each question carefully and answer every question honestly.

❏ Yes ❏ No Has a physician ever diagnosed you with a heart condition and recommended only medically supervised physical activity?
❏ Yes ❏ No When you perform physical activity, do you feel pain in your chest?
❏ Yes ❏ No Do you ever faint or get dizzy and lose your balance, or consciousness?
❏ Yes ❏ No Do you have a bone or joint problem that could be aggravated by physical activity?
❏ Yes ❏ No Do you have high blood pressure or a heart condition for which a physician is currently prescribing a medication?
❏ Yes ❏ No Are you pregnant or have you given birth within the last 6 months?
❏ Yes ❏ No Do you have insulin dependent diabetes, or do you have hypoglycemia?
❏ Yes ❏ No Do you suffer from exercise-induced asthma?
❏ Yes ❏ No Are you 65 years of age or older and not used to being very active?
❏ Yes ❏ No Have you had a recent surgery, and/or are you on any medication?
❏ Yes ❏ No Have you had a stroke?
❏ Yes ❏ No Are you aware, through your own experience or a doctor's advice, of any other physical reason against your exercising without medical supervision?
❏ Yes ❏ No Have you consulted your physician regarding increasing your physical activity and/or performing a fitness assessment?
❏ Yes ❏ No If you answered NO to the previous question, will you consult your physician prior to increasing your physical activity and/or performing a fitness assessment?

If you answered yes to any of the above questions, talk with your doctor before you become more physically active. Tell your doctor your plan to exercise and to which questions you answered yes. If you honestly answered no to all questions you can be reasonably certain you can safely increase your level of physical activity gradually. If your health changes so you then answer yes to any of the above questions, seek guidance from a physician.

Participant's Signature: ____________________________ Date: ____________________

Personal Medical History

Have you ever had (or currently have) any of the following? (please check all that apply)

❏ Heart Attack ❏ Stroke ❏ Shortness of Breath ❏ Angina ❏ Diabetes
❏ Rheumatic Fever ❏ High Blood Pressure ❏ Gout ❏ Heart Murmur
❏ High Cholesterol ❏ Rapid Heart Beats at Rest ❏ Skipped Heart Beats ❏ Extra Heart Beats

If yes, please explain: ____

Are you currently taking any medication (depression/High BP)? ❏ Yes ❏ No

If yes, please list and explain: ____

Family History

Please put a check in front of any statements that apply to your family history.

❏ Parent died of heart attack prior to age 50
❏ Sibling died of heart attack prior to age 50
❏ Parents, siblings with high blood pressure
❏ Parents, siblings with stroke
❏ Parents, siblings with diabetes
❏ Other

Please explain: ____

Personal Pulmonary Hygiene

Have you ever had (or currently have) any of the following? (please check all that apply)

❏ Asthma ❏ Bronchitis ❏ Home Oxygen ❏ Emphysema
❏ Tuberculosis ❏ Pneumonia ❏ Allergies

If yes, please explain: ____

Muscular/Bone/Joint History

Have you ever had (or currently have) any of the following (please check all that apply)?

❏ Arthritis ❏ Knee problems ❏ Back injury/problems ❏ Muscular pain/injuries
❏ Muscular Weakness ❏ Hip problems ❏ Painful joints ❏ Tendonitis

If yes, please explain: ____

Other Medical Problems

Have you ever had (or currently have) any of the following? (please check all that apply)

❏ Dizziness ❏ Blood Disorder ❏ Lyme Disease ❏ Epilepsy ❏ Nervousness
❏ Convulsions ❏ Cancer ❏ Headaches ❏ Kidney Disease ❏ Anemia
❏ Thyroid Disorder ❏ Depression ❏ Other

If yes, please explain: ____

Have you had surgery or been in a hospital for medical treatment? ❏ Yes ❏ No

If yes, please explain: ____

Are you under any type of medical observation or receiving treatment? ❏ Yes ❏ No

If yes, please explain: ____

Do you smoke? ❏ Yes ❏ No How many cigarettes, packs per day? ______
Do you drink alcohol? ❏ Yes ❏ No
Do you currently exercise? ❏ Yes ❏ No

Exercise Goals and Intent

What is your main goal for exercising?

❏ Weight Loss ❏ Building muscle ❏ Shaping & toning ❏ Building strength
❏ Weight gain ❏ Overall health ❏ Lower blood pressure/cholesterol

If other, please explain: ______________________________

In 6 months, how would you like to describe your body, physical vitality or performance? ______________

Why is this outcome important to you? ______________________________

How long have you been thinking about getting into better shape? ______________________

How do you envision your trainer facilitating your success? ______________________

What are your short term goals? ______________________________

What are your long term goals? ______________________________

How will you reward yourself for reaching your short term goals? ______________________

What will be your reward for reaching your long term goals? ______________________

CANCELLATION POLICY

There is a 24 hour cancellation policy for private, semi-private, and group sessions. If not cancelled within 24 hours you will be subject to be charged for the missed session.

Name: ______________________ Date: ______________

INFORMED CONSENT

I hereby voluntarily give consent to engage in physical fitness. I understand there are certain changes which may occur during exercise. They include abnormal blood pressure, fainting, disorders of heart beat, and very rare instances of heart attack. I understand that every effort will be made to minimize problems during exercise.

I understand that I am responsible for monitoring my own condition when exercising, and should any unusual symptoms occur, I will cease my participation and inform the trainer of the symptoms. Unusual symptoms include, but are not limited to: chest discomfort, nausea, difficulty in breathing, and joint or muscle injury. Also, in consideration of being allowed to participate in the fitness tests, I agree to assume all risks of such exercise, and hereby release and hold harmless the Levine Jewish Community Center, and their agents and employees, from any and all health claims, suits, losses, or causes of action for damages, for injury or death, including claims for negligence, arising out of or related to my participation in physical fitness.

I have read the foregoing carefully and I understand its content. Any questions which may have occurred to me concerning this informed consent have been answered to my satisfaction.

Name: ______________________ Date: ______________

Witness: ______________________ Date: ______________