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ELFORD FITNESS
PREMIER PERSONAL TRAINING

Physical Activity Readiness Questionnaire (PAR-Q)

All of the information you provide in this questionnaire is strictly confidential and will become part of your training record.

Client Name (please print):_____
If you circle "yes" to any of these questions, please provide details such as date of occurrence, frequency, intensity, etc.

1. Yes. No. Do you suffer from back pain?
2. Yes. No. Are you sensitive to touch/pressure in any area?
3. Yes. No. Do you have tension, numbness or pain in a specific area?
4. Yes. No. Do you experience frequent headaches?
5. Yes. No. Are you pregnant? If yes, when are you due:
6. Yes. No. Do you have high blood pressure?
7. Yes. No. Do you have high cholesterol?
8. Yes. No. Are you epileptic?
9. Yes. No. Have you ever had surgery?
10. Yes. No. Have you ever broken any bones?
11. Yes. No. Do you experience stiff, swollen or painful joints?
12. Yes. No. Do you have difficulty sleeping?
13. Yes. No. Do you experience fatigue or lack of energy?
14. Yes. No. Do you experience cold hands or feet?
15. Yes. No. Have you ever been advised by a physician to avoid any type of exercise?
16. Yes. No. Have you ever been knocked unconscious or suffered a concussion?
17. Yes. No. Do you (or does someone in your family) have a cardiac condition?
18. Yes. No. Do you have any allergies?
19. Yes. No. Are you currently taking any medications?
20. Yes. No. Have you ever seen a Nutritionist/Registered Dietician?

21. Yes. No. Do you smoke or have you smoked in the past?

22. Yes. No. Do you live with a smoker?

23. Yes. No. Do you drink coffee?

24. Do you have a "chief complaint"? (If No please Skip to question 30)

25. Please state how long you have had this complaint, when you first noticed it and what you feel may have caused the problem:

26. How does your "chief complaint" affect you on a day-to-day basis? Please state what you CAN and CANNOT do any more.

27. Yes. No. Are the symptoms brought on by certain activities or positions?

28. Yes. No. Is the pain worse at certain times of day?

29. Yes. No. Do specific activities or positions alleviate your symptoms?

30. Yes. No. Do you have an ergonomically set up desk/workstation?

31. How many hours do you spend in front of a computer?

32. On a scale of 1 to 10 (1=no stress, 10=a lot of stress), please rate the amount of stress in your career.

33. On a scale of 1 to 10 (1=no stress, 10=a lot of stress), please rate the amount of stress in your personal life.

34. What previous treatment(s) have you tried? Please state what and when.

35. What time do you usually go to bed at night and wake up in the morning?

36. How many meals do you eat each day? List the number and time of day you usually eat these meals.

Client Signature: _____ Date: _____

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Health Check and Goal Setting

All of the information you provide is strictly confidential and will become part of your training record.

Client Name (please print):_____

- Please Tick any of the below that relates to your training goal

Body Shape		**Weight Loss**		**Mass Gain**		**Building Lean Muscle**	
Every day Health		**Increase Strength**		**Sports Specific**		**Lowering Blood Pressure / Cholesterol**	

- What is your overall fitness objective? _____
- Why is this important to you? _____
- Is there a time period in which you want to see/feel results? _____

Blood Pressure:		Hip (cm):	
Resting Heart Rate:		Arm (inches):	
Weight (Kgs):		Dress/Waist Size:	
Height (cm):		Chest (inches):	
Waist (cm):			

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Breaking down your goal into specific areas

1) _____

2) _____

3) _____

- What had stopped you from either getting starting or staying on a consistent exercise and nutritional program in the past?

  _____

- Are you participating in any physical activity now? What & how often?_____

  _____

- If not, how long has it been since you've been involved in a regular exercise program? _____

  _____

- Is there any area of you body that you want to specifically work on?_____

  _____

- How much time per week are you willing to commit towards accomplishing your fitness goals?

  _____

- What type of cardiovascular exercise do you enjoy the most?_____

- Do you have any dietary restrictions? ex: lactose intolerant, diabetic, hypoglycemic etc..._____

- Is there any thing not previously mentioned that would prevent you from getting starting on a regular exercise program today?

  _____

Client Signature : _____ Date : _____

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Client Trainer Agreement

What you can expect from me:

1. I will provide you with at least 14 days notice if I am going out of town for more than 5 days.

2. If I become suddenly ill or have an unexpected emergency and have to cancel last minute, you will not be charged for the session, and I will reschedule the session as quickly as possible.

3. If I am going to be late to a session I will phone and be more then happy to add the late time to a future session or if possible, go over the scheduled hour.

In order to make your sessions more effective I will need for YOU, as my client, to have the following understandings:

1. If a session is cancelled without 24 hours notice , YOU will be charged for that session. Family emergencies or *sudden* illness will be exempt. (Sudden means falling ill that day/night)

2. Rescheduling sessions will be accommodated if possible.

3. Occasional time changes are okay; however, constant time changes may result in loss of time slot.

4. If YOU are more than 20 minutes late for a session and have not phoned or text me, this will be considered a non-attendance and YOU will be charged for the session. If YOU have pre paid for any of the Training packages then 1 session will be deducted from the total.

5. Payment for individual sessions are due at the end of each session.
Payment for packages are due after the first session of a chosen package. Those sessions that go unused will carry over to the following month, but not after the second month. In other words, sessions purchased at the beginning of month are good for 60 days, but no longer.

By signing this release, I acknowledge that I understand its content and that this release cannot be modified orally.

Signed: _____

Printed Name: _____

Trainer's Signature_____

Dated: ___/___/___

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WAIVER & RELEASE FORM

While training with Michael James Melford.

I understand that physical exercise can be strenuous and subject to risk of serious injury, you are urged to obtain a physical examination from a doctor before participating in any exercise activity. You (**PRINT NAME**_____) agree that if you engage in any physical exercise or activity, you do so **entirely at your own risk**.

Any recommendation for changes in diet including the use of food supplements and weight reduction products are entirely your responsibility and you should consult a physician prior to undergoing any dietary or food supplement changes. You agree that you are voluntarily participating in these activities and **assume all risks** of injury, illness or death.

This waiver and release of liability includes, without limitation, all injuries which may occur as a result of: (a) your participation in any activity or personal training session and (b) instruction, training, supervision, or dietary recommendations by your Personal Trainer.

You acknowledge that you have carefully read this "waiver and release" and fully understand that it is a **release of liability**. You expressly agree to release and discharge your Personal Trainer from any and all claims or causes of action and you agree to voluntarily give up or waive any right that you may otherwise have to bring a legal action against your Trainer for personal injury or property damage.

To the extent that statute or case law does not prohibit release for negligence, this release is also for negligence on the part of the Personal Trainer.

If any portion of this release from liability shall be deemed by a Court of competent jurisdiction to be invalid, then the remainder of this release from liability shall remain in full force and effect and the offending provision or provisions severed here from.

By signing this release, I acknowledge that I understand its content and that this release cannot be modified orally.

Signed: _____

Printed Name: _____

Dated: ___/___/___

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Food Diary for Date _____

Food Group	Food Name and Amount
Breakfast	
Grains/Starches	
Vegetables	
Fruits	
Dairy	
Protein	
Fats/Sweets	
Beverages	
Comments	
Snack	
Lunch	
Grains/Starches	
Vegetables	
Fruits	
Dairy	
Protein	
Fats/Sweets	
Beverages	
Comments	
Snack	
Dinner	
Grains/Starches	
Vegetables	
Fruits	
Dairy	
Protein	
Fats/Sweets	
Beverages	
Comments	
Snack	

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Food Diary for Date _____

Food Group	Food Name and Amount
Breakfast	
Grains/Starches	
Vegetables	
Fruits	
Dairy	
Protein	
Fats/Sweets	
Beverages	
Comments	
Snack	
Lunch	
Grains/Starches	
Vegetables	
Fruits	
Dairy	
Protein	
Fats/Sweets	
Beverages	
Comments	
Snack	
Dinner	
Grains/Starches	
Vegetables	
Fruits	
Dairy	
Protein	
Fats/Sweets	
Beverages	
Comments	
Snack	