STARPORT
NASA EXCHANGE - JSC

PERSONAL TRAINING PAR-Q

First Name: _____Last Name:_____
Address: _____City:_____ST:_____Zip:_____
Best Contact Phone: (_____)_____ Birth Date: _____/_____/_____
Email: _____ Gender: M/F Age: _____ Height: _____Weight: _____
Employer: _____ Best Day for Training: M T W TH F Sa Sun Time(s):_____
Date: _____ Fitness Professional: _____

Health History

Please read each question carefully. Initial in the space provided indicating that you understand what is recommended Physical activity should not be hazardous for most people. The questions are designed to identify those who should consult a physician prior to beginning a program of physical exercise.

	Yes	No
1. Has a doctor ever said you have a heart condition and recommended medically supervised physical activity?	❑	❑
2. Do you have chest pain brought on by physical activity	❑	❑
3. Do you tend to lose consciousness, feel faint or have spells of dizziness?	❑	❑
4. Has your doctor recommended medication for blood pressure?	❑	❑
5. Do you have a bone or joint problem (such as arthritis) that could be aggravated by physical activity? **Explain:**	❑	❑
6. Are you aware of any other physical reason against your exercising without medical supervision? **Explain:**	❑	❑
7. Are you over the age of 65 and not accustomed to vigorous exercise?	❑	❑

If you answered YES to one or more of the questions above, please answer the following questions:

Have you consulted your physician regarding increasing your physical activity and or performing a fitness assessment?
❑ Yes ❑ No **Initial** _____
If NO, will you consult your physician prior to increasing your physical activity and/or performing a fitness assessment?
❑ Yes ❑ No **Initial** _____

Please check all conditions that apply:

❑ Monitored by Physician	❑ Kidney Disease	❑ Depression
❑ Heart Disease or Stroke	❑ Osteoporosis	❑ Compulsive Overeating
❑ High Blood Pressure	❑ Diabetes Mellitus	❑ Anorexia/Bulimia
❑ Prostate Disease	❑ Anemia	❑ Ulcer
❑ Gallbladder Disease	❑ Obesity	❑ Gastrointestinal Disease
❑ High Triglycerides	❑ Arthritis	❑ Food Allergies
❑ Cancer	❑ Low-back pain in last 6 months	❑ Pregnant/Lactating
❑ Lung/Pulmonary Disease	❑ Neuromuscular Disease	❑ Trying to conceive
❑ Arteriosclerosis	❑ Psychological Problems	

Please list any medications you are currently taking below:

Notes:

Goal Questions

What is your primary fitness goal?
Have you ever participated in a fitness program? ❑ Yes ❑ No If so, describe:
Did you get results? ❑ Yes ❑ No Describe:
Were results permanent? ❑ Yes ❑ No
On average, how long do you stick with a program before giving up?
What was your reason for quitting?
When did you first begin to think about getting in shape or getting back into shape?
What has prevented you from maintaining or achieving your fitness goals in the past?
When were you in the best shape of your life?
What do you weigh today? _____
What did you weigh 5 years ago? _____
What size do you wear today? _____
What size did you wear 5 years ago? _____

Lifestyle Questions

Do you: **Eat 3 Meals Per Day:** ❑Yes ❑No
Do you eat **5 servings** of Fruits/Veggies a Day? ❑ Yes ❑ No
Do you Eat Fast Food: ❑ Yes ❑ No
How many times per week? _____
Drink Alcohol: ❑ Yes ❑ No
How many times per week? _____
Eat Restaurant Food: ❑ Yes ❑ No
How many times per week? _____
Drink Coffee: ❑ Yes ❑ No
Smoke: ❑ Yes ❑ No
Eat Snacks: ❑ Yes ❑ No
Drink Soft Drinks ❑ Yes ❑ No
How many per day? _____
Watch TV: ❑ Yes ❑ No
How many hrs per day?_____
Take Supplements: ❑ Yes ❑ No
Get 7 Hrs. of Sleep Daily: ❑ Yes ❑ No
Are you Married: ❑ Yes ❑ No
Do you have Children: ❑ Yes ❑ No
Describe your occupation:
Describe your Hobbies:
What do you like to do for Fun?
Rate your Motivation: 1 2 3 4 5 6 7 8 9 10

RELEASE AND WAIVER OF LIABILITY
MEMBER'S ACKNOWLEDGEMENT AND ASSUMPTION OF RISK AND FULL RELEASE FROM LIABILITY

Member acknowledges that the personal training/fitness assessment hereunder includes participation in strenuous physical activities, including but not limited to, aerobic movement, weight training, stationary bicycling, various aerobic conditioning machines and various nutritional programs offered by STARPORT. Member agrees to assume all risk and responsibility involved with participation in the physical activities. Member affirms that he/she is in good physical condition and does not suffer from any disability that would prevent or limit participation in physical activities. Member acknowledges that participation will be physically and mentally challenging, and member agrees that it is the responsibility of the member to seek competent medical or other professional advice, regarding any concerns involved with the ability of member to take part in STARPORT physical activities. Member agrees to assume all risks in responsibility for not exceeding his/her physical limits.

MEMBER SIGNATURE _____ Date _____