



## Fitness Assessment & Personal Training Registration Packet

Thank you for your interest in the Springfield College Personal Training program. It is our goal to assist you in reaching your personal fitness goals. These sessions will focus on developing your fitness program according to your fitness level, goals, time commitments and interests. If you have any questions regarding the questionnaire or the personal training program, you can reach the Fitness & Wellness Graduate Associate at x3723.

### I. Participant Information

Last Name:		First Name:	
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female		Date of Birth:	
Primary Phone #:		Secondary Phone #:	
Street Address:		Town:	
State:	Zip Code:	Emergency Contact:	
Emergency Phone #(s):			

Select the appropriate category that describes you:

- |   |   |
|---|---|
| <input type="checkbox"/> Full-Time Undergraduate Student<br><input type="checkbox"/> Part-Time Undergraduate Student<br><input type="checkbox"/> Employee | <input type="checkbox"/> Full-Time Graduate Student<br><input type="checkbox"/> Part-Time Graduate Student<br><input type="checkbox"/> Other: _____ |
|---|---|

Please select one:

*(Please note that students and employee wellness participants receive one free assessment per academic year. Employee wellness participants also receive two complimentary personal training sessions.)*

- I am registering for a Fitness Assessment only.
  
- I am registering for Personal Training sessions.
  - # of sessions registering for: \_\_\_\_\_
  - Have you completed a Fitness Assessment?  Yes  No
  - If yes, when? \_\_\_\_\_
  - Trainer Preference (if applicable): \_\_\_\_\_
  - Are you registering with a partner or group?  Yes  No
  - If yes, please list their names:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

## Instructions

1. Complete the series of questions that follow. The information you provide will play an important role in developing appropriate exercise sessions and determining if medical clearance is necessary.
2. If you are registering to train with a partner or small group, we recommend that you have similar fitness goals and similar fitness levels.
3. Turn in your completed Registration Packet to the Campus Recreation office. If medical clearance is required, the Fitness & Wellness Graduate Associate will contact you and will complete a physician's approval form which you will need to pick up from the Campus Recreation office. This form must be completed by your physician and returned to the office.
4. Appointments will be scheduled according to your availability. Unused sessions will expire six months from the date of registration.
5. A personal trainer will call you to schedule your fitness assessment or initial personal training session.
6. Once you have completed the number of sessions you have registered for, you may purchase additional sessions in the Campus Recreation office. You will be asked to complete a payment fee authorization form. The Springfield College Business Office will then bill you for the amount due. You must show a copy of your payment fee authorization form for additional sessions to your personal trainer.
7. Cancellation Policy: If you need to cancel or reschedule an appointment, please contact your trainer or the Fitness & Wellness GA at least 24 hours in advance or you will forfeit that session. If you are late for a session, the session will still end at the original time.
8. Be sure to read and keep the last page of the Registration Packet for a complete list of policies.

*Please complete the availability log below. Place an "x" in the time slots that you ARE available.*

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
7:00 am							
8:00 am							
9:00 am							
10:00 am							
11:00 am							
12:00 pm							
1:00 pm							
2:00 pm							
3:00 pm							
4:00 pm							
5:00 pm							
6:00 pm							
7:00 pm							
8:00 pm							
9:00 pm							
10:00 pm							

## II. Health History Questionnaire

Assess your health status by marking all the true statements:

<p><b>History</b>          You have had:  <input type="checkbox"/> a heart attack  <input type="checkbox"/> heart surgery  <input type="checkbox"/> cardiac catheterization  <input type="checkbox"/> coronary angioplasty (PTCA)  <input type="checkbox"/> pacemaker/implantable cardiac defibrillator/rhythm disturbance  <input type="checkbox"/> heart valve disease  <input type="checkbox"/> heart failure  <input type="checkbox"/> heart transplantation  <input type="checkbox"/> congenital heart disease</p> <p><b>Symptoms</b>  <input type="checkbox"/> You experience chest discomfort with exertion  <input type="checkbox"/> You experience unreasonable breathlessness  <input type="checkbox"/> You experience dizziness, fainting, or blackouts  <input type="checkbox"/> You take heart medications</p> <p><b>Other Health Issues</b>  <input type="checkbox"/> You have diabetes  <input type="checkbox"/> You have asthma or other lung disease  <input type="checkbox"/> You have burning or cramping sensation in your lower legs when walking short distances  <input type="checkbox"/> You have musculoskeletal problems that limit your physical activity  <input type="checkbox"/> You have concerns about the safety of exercise  <input type="checkbox"/> You take prescription medication(s)  <input type="checkbox"/> You are pregnant</p>	<p><i>If you marked any of the statements in this section, approval from your physician or other appropriate health care provider is required before engaging in our personal training program.</i></p>
<p><b>Cardiovascular Risk Factors</b>  <input type="checkbox"/> You are a man older than 45 years  <input type="checkbox"/> You are a woman older than 55 years, have had a hysterectomy, or are postmenopausal  <input type="checkbox"/> You smoke, or quit smoking within the previous 6 months  <input type="checkbox"/> Your blood pressure is &gt;140/90 mm Hg  <input type="checkbox"/> You do not know your blood pressure  <input type="checkbox"/> You take blood pressure medication  <input type="checkbox"/> Your blood cholesterol level is &gt;200 mg/dL  <input type="checkbox"/> You do not know your cholesterol level  <input type="checkbox"/> You have a close relative who had a heart attack or heart surgery before age 55 (father or brother) or age 65 (mother or sister)  <input type="checkbox"/> You are physically inactive (i.e. you get &lt;30 minutes of physical activity on at least 3 days per week)  <input type="checkbox"/> You are &gt;20 pounds overweight</p>	<p><i>If you marked two or more of the statements in this section approval is required from your physician or other appropriate health care provider before engaging in our personal training program.</i></p>
<p><input type="checkbox"/> None of the above</p>	<p><i>You should be able to exercise safely without consulting your physician or other appropriate health care provider.</i></p>

*Please answer the following questions thoroughly:*

1. Do you have any neck, back, knee, hip, shoulder, or other skeletal problems that will be made worse by or limit your ability to exercise?  No  Yes

If yes, please explain:

2. Have you had a recent hospitalization, surgery, or illness?

If yes, please explain:

3. Please list any other medical issues, past/current injuries, or possible concerns:

### **III. Activity Questionnaire & Goal Setting**

1. When was the last time you were physically active?  
 Never       Presently       In the past (dates: \_\_\_\_\_ )

2. Please give a brief description of your last or present physical routine, if applicable.

3. If you are not still following this routine, why did you stop?

4. What are some of your favorite activities?

5. Are there certain activities that you avoid due to dislike, discomfort etc.? Why?

6. What is your occupation?

7. Are you physically active in your daily routine?

8. About how much sleep do you get?

\_\_\_\_\_ Weekdays      \_\_\_\_\_ Weekends

9. What are your primary fitness goals?

10. What level of motivation do you have to change your exercise habits?

High       Moderate       Low

11. Can you foresee any barriers that might interfere with reaching your goals?

12. Do you feel that you need to make any changes to your eating habits?

13. Do you feel that you can successfully make these changes in your diet?

14. What kind of time commitment are you (realistically) planning on dedicating to your fitness program (days/weeks and minutes/session)?

15. What factors contribute to stress in your life and what do you do to manage your stress?

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I understand that participating in the Springfield College Campus Recreation Personal Training Program is purely voluntary and that neither the Division of Student Affairs nor Springfield College assumes the responsibility for any injury sustained through my participation. I am aware of the risks inherent in participation of physical activity and agree that it is my responsibility to determine whether or not I am physically fit to participate in this program. I give permission for Springfield College to use my picture for marketing materials and publications.

Signature of Participant: \_\_\_\_\_ Date: \_\_\_\_\_

## MEDICAL INFORMATION RELEASE

Each participant in the Fitness Assessment and Personal Training Program must complete the following sections, even though physician approval may not be necessary in every case. All men over the age of 45 years old and women over the age 55 years old must obtain physician approval.

If medical clearance is necessary in your case, the Fitness & Wellness Graduate Associate will contact you and will complete a physician's approval form which you will need to pick up from the Campus Recreation office. This form must be completed by your physician and returned to the Campus Recreation office.

*I hereby give my physician permission to release any pertinent medical information from my medical records to the Campus Recreation staff of Springfield College. I understand that this information will be kept confidential. I am aware that this release will expire within one year of signature and that I may revoke the medical release at any time.*

Participant's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Participant's Signature: \_\_\_\_\_

Today's Date: \_\_\_\_\_

Physician Information		
Name of Physician(s)	Address	Contact Numbers
		Phone: Fax:
		Phone: Fax:
		Phone: Fax:



## Fitness Assessment and Personal Training Information Sheet

### *Client Copy*

*Please retain for your records and for reference in the future.*

Thank you for participating in the Springfield College Campus Recreation Fitness Assessment and Personal Training Program. To ensure that you get the most out of your personal training package and/or fitness assessment, we have listed the following policies and information you will need to know.

- **Registration Time:** The total time for client-trainer set up is generally two to seven business days, depending on the need to have you cleared by a physician.
- **Session Length:** All personal training sessions are one hour in length.
- **Fitness Assessments:** Fitness assessments will include two one hour sessions. The first session will include a consultation and exercise testing. The second session will include an analysis of your test results and the prescription of a general exercise program.
- **Initial Personal Training Session:** If you have not previously completed an assessment, the first session will include a consultation and exercise testing. If you have completed an assessment, the first session will include a consultation.
- **Late Policy:** Trainers are obligated to wait only 15 minutes for clients. After 15 minutes have passed, the trainer is not required to lead the session and the session may be voided. Sessions starting late will be completed one hour from the original, scheduled start time.
- **Cancellation Notice:** You are asked to call your trainer at least 24 hours before the scheduled training session if you anticipate a cancellation. Otherwise, you will lose this session.
- **Partner/Group Training:** If you are registering with a partner or group, each of you must complete a separate registration packet. All packets must be submitted and all members of the group must be cleared medically (if applicable) before the trainer will contact you.
- **Session Expiration:** All personal training sessions expire six months from the registration/purchase date. All packages are non-refundable. Extenuating circumstances will be considered by the Campus Recreation staff. A refund will be granted for medical emergencies and a physician's signature will be required.
- **Shadowing:** For the continued growth of our program and support of the professional development of Springfield College students, we sometimes allow our trainers to be shadowed.