

# **Personal Training Program Registration**

**Elective/Voluntary Activity Waiver**

**Medical Clearance**

**Medical Release**

**Medical/Health Status Questionnaire**

**Exercise Habits & Interests Questionnaire**

**Personal Fitness & Lifestyle Goals Questionnaire**



**FOR YOUTH DEVELOPMENT®  
FOR HEALTHY LIVING  
FOR SOCIAL RESPONSIBILITY**

**Elective/Voluntary Activity Waiver**

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Participant's Name (Please Print) \_\_\_\_\_

### **Southeast Family Branch – YMCA of Greater Louisville**

#### **Waiver of Liability, Assumption of Risk, and Indemnity Agreement**

**Waiver:** In consideration of being permitted to participate in any way in YMCA Personal Training Programs, I, for myself, my heirs, personal representatives or assigns, **do hereby release, waive, discharge, and covenant not to sue** the YMCA and its respective officers, employees, and agents from liability from any and all claims including those which result in personal injury, accidents or illnesses (including death), and property loss arising from, but not limited to, participation in YMCA Personal Training Programs.

\_\_\_\_\_  
Signature of Parent of Minor (under 18)      Date

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

\_\_\_\_\_  
Printed Name - Parent of Minor (under 18)      Date

\_\_\_\_\_  
Printed Name - Participant      Date

**Assumption of Risks:** Participation in Personal Training Programs carries with it certain inherent risks that cannot be eliminated regardless of the care taken to avoid injuries. The specific risks vary from one activity to another, but the risks range from 1) minor injuries such as scratches, bruises, and sprains to 2) major injuries such as eye injury or loss of sight, joint or back sprains, strains, breaks, concussions, cuts, cardiac arrest, partial or total paralysis, drowning and death. We strongly recommended that you consult your personal physician before starting any personal training program.

**I have read the previous paragraphs and I know, understand, and appreciate these and other risks that are inherent in Personal Training Programs. I hereby assert that my participation is voluntary and that I knowingly assume all such risks.**

**Indemnification and Hold Harmless:** I also agree to INDEMNIFY AND HOLD the YMCA HARMLESS from any and all claims, actions, suits, procedures, costs, expenses, damages and liabilities, including attorney's fees, brought as a result of my involvement in YMCA Personal Training Programs and to reimburse it for any such expenses incurred.

**Acknowledgment of Understanding:** I have read this waiver of liability, assumption of risk, and indemnity agreement, fully understand its terms, and **understand that I am giving up substantial rights, including my right to sue.** I acknowledge that I am signing the agreement freely and voluntarily, and **-intend by my signature to be a complete and unconditional release of all liability** to the greatest extent allowed by law.

\_\_\_\_\_  
Signature of Parent of Minor (under 18)      Date

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

\_\_\_\_\_  
Printed Name - Parent of Minor (under 18)      Date

\_\_\_\_\_  
Printed Name - Participant      Date

## **Medical Clearance**

Write "Y" for yes or "N" for no to all medical problems that you have experienced within one year (unless indicated). If you answer "Yes" to any question, please have your doctor complete the medical release for on the last page of this packet. Please do not leave any questions blank.

- |  |  |
|--|--|
| <input type="checkbox"/> History of heart problems, chest pain or stroke   | <input type="checkbox"/> Increased blood pressure  |
| <input type="checkbox"/> Any chronic illness or condition  | <input type="checkbox"/> Difficulty with physical exercise                                 |
| <input type="checkbox"/> Advice from physician not to exercise   | <input type="checkbox"/> Recent surgery (last 12 months)                                   |
| <input type="checkbox"/> Pregnancy (now or within last 3 months)   | <input type="checkbox"/> History of breathing or lung problems                             |
| <input type="checkbox"/> Muscle, joint, or back disorder, or previous injury still affecting you   | <input type="checkbox"/> Diabetes or thyroid condition                                     |
| <input type="checkbox"/> Loss of balance due to dizziness  | <input type="checkbox"/> Increased blood cholesterol                                       |
| <input type="checkbox"/> Loss of consciousness   | <input type="checkbox"/> Hernia or any condition that may be aggravated by lifting weights |
| <input type="checkbox"/> Do you smoke or have you quit smoking within the last 3 months?   |  |
| <input type="checkbox"/> Are you taking any medication for blood pressure or a heart condition?  |  |
| <input type="checkbox"/> History of heart problems in immediate family (myocardial infarction, coronary revascularization or sudden death before 55 years of age in father or other male 1 <sup>st</sup> degree relative (i.e. brother or son) or before 65 years of age in mother or other female 1 <sup>st</sup> degree relative (i.e. sister or daughter) |  |

### If You Answered:

#### YES to two or more questions...

Your physician must complete our medical release form prior to your initial session with a YMCA personal trainer for a fitness assessment or to begin your exercise program.

- You may be able to participate in physical activity. With a medical doctor's approval, the safest approach is to begin slowly and gradually increase the intensity & duration of your exercises. Or, you may need to restrict your activities to those that are safest. Talk to your doctor about the kinds of activities you wish to participate in and follow his/her advice.

#### NO to ALL questions...

If you answered "NO" to all above questions, you can be reasonably sure that you can:

- Start becoming much more physically active – begin slowly and build up gradually. This is the safest approach.
- Schedule your initial meeting with a YMCA personal trainer for a fitness assessment or to begin your exercise program \*(without a medical doctor's clearance).

\* The YMCA recommends that you consult your physician prior to beginning an exercise program.

I have read, understood and completed the questionnaire. Any questions that I had were answered to my full satisfaction.

Print Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

### Medical History - Detail

- ☐ Are you currently being treated for high blood pressure?

If you know your average blood pressure, please enter: \_\_\_\_\_ / \_\_\_\_\_

Please check all conditions or diagnoses that apply:

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Abnormal EKG?         | <input type="checkbox"/> Limited Range of Motion?   | <input type="checkbox"/> Stroke?                                  |
| <input type="checkbox"/> Abnormal Chest X-Ray? | <input type="checkbox"/> Arthritis?                 | <input type="checkbox"/> Do You Suffer from Epilepsy or Seizures? |
| <input type="checkbox"/> Rheumatic Fever?      | <input type="checkbox"/> Bursitis?                  | <input type="checkbox"/> Chronic Headaches or Migraines?          |
| <input type="checkbox"/> Low Blood Pressure?   | <input type="checkbox"/> Swollen or Painful Joints? | <input type="checkbox"/> Persistent Fatigue?                      |
| <input type="checkbox"/> Asthma?               | <input type="checkbox"/> Foot Problems?             | <input type="checkbox"/> Stomach Problems?                        |
| <input type="checkbox"/> Bronchitis?           | <input type="checkbox"/> Knee Problems?             | <input type="checkbox"/> Hernia?                                  |
| <input type="checkbox"/> Emphysema?            | <input type="checkbox"/> Back Problems?             | <input type="checkbox"/> Anemia?                                  |
| <input type="checkbox"/> Other Lung Problems?  | <input type="checkbox"/> Shoulder Problems?         | <input type="checkbox"/> Are You Pregnant?                        |
|  | <input type="checkbox"/> Recently Broken Bones?     |   |

☐ Has a doctor imposed any activity restrictions? If so, please describe:

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## Medications

Please Select Any Medications You Are Currently Using:

<input type="checkbox"/> Diuretics	<input type="checkbox"/> Other Cardiovascular
<input type="checkbox"/> Beta Blockers	<input type="checkbox"/> NSAIDS/Anti-inflammatories (Motrin, Advil)
<input type="checkbox"/> Vasodilators	<input type="checkbox"/> Cholesterol
<input type="checkbox"/> Alpha Blockers	<input type="checkbox"/> Diabetes/Insulin
<input type="checkbox"/> Calcium Channel Blockers	<input type="checkbox"/> Other Drugs (record below).

Please list the specific medications that you currently take:

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## Lifestyle

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Dietary Habits. Please Select All That Apply.

- |  |  |
|--|--|
| <input type="checkbox"/> I seldom consume red or high-fat meats. | <input type="checkbox"/> I eat at least 5 servings of fruits/vegetables per day. |
| <input type="checkbox"/> I pursue a low-fat diet.                | <input type="checkbox"/> I almost always eat a full, healthy breakfast.          |
| <input type="checkbox"/> My diet includes many high-fiber foods. | <input type="checkbox"/> I rarely eat high-sugar or high-fat desserts.           |

## Other

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Please Indicate Any Other Medical Conditions or Activity Restrictions That You May Have. It is important that this information be as accurate and complete as possible

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- ☐ Is any of this information critical to understanding your readiness for exercise? Are there any other restrictions on activity that we should know about?

# Exercise Habits & Interests Questionnaire

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

Your Name: \_\_\_\_\_

**Recent Exercise Habits:**

How many times per week are you active enough to break a sweat? \_\_\_\_\_

When you exercise, how long are you active? \_\_\_\_\_ minutes

On a scale of 1 to 10, how intense is your typical activity? \_\_\_\_\_

How many years have you exercised? \_\_\_\_\_

**In a Typical Week, How Many Minutes Do You Spend in the Following Activities?**

Running/Jogging \_\_\_\_\_

Walking \_\_\_\_\_

Aerobics \_\_\_\_\_

Racquet Sports \_\_\_\_\_

Swimming \_\_\_\_\_

Weight Training \_\_\_\_\_

Biking \_\_\_\_\_

Skiing \_\_\_\_\_

Stair Climber \_\_\_\_\_

Yoga/Pilates \_\_\_\_\_

**Place a Check Next to Your Activity Preferences or Interests:**

☐ Aerobics Class

☐ Free Weights

☐ Golf

☐ Group Activities

☐ Martial Arts

☐ Outdoor Cycling

☐ Running

☐ Spinning

☐ Step Aerobics

☐ Swimming

☐ Tennis

☐ Walking

☐ Others

## Personal Fitness & Lifestyle Goals Questionnaire

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

Your Name: \_\_\_\_\_

In striving to achieve a higher state of wellness or fitness, a set of clearly articulated goals is essential. These goals will help to guide your lifestyle choices such as when and what to eat, how often and how intensely to exercise, and how to overcome the challenges and barriers you will surely encounter.

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**Please indicate your personal health and fitness goals:**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Lose Weight       | <input type="checkbox"/> Stop Smoking      | <input type="checkbox"/> Feel Better      |
| <input type="checkbox"/> General Fitness   | <input type="checkbox"/> Sports Specific   | <input type="checkbox"/> Flexibility      |
| <input type="checkbox"/> Reduce Stress     | <input type="checkbox"/> Lower Cholesterol | <input type="checkbox"/> Muscular Size    |
| <input type="checkbox"/> Muscular Strength | <input type="checkbox"/> Look Better       | <input type="checkbox"/> Reduce Back Pain |
| <input type="checkbox"/> Improve Diet      | <input type="checkbox"/> Aerobic Fitness   | <input type="checkbox"/> Injury Rehab     |
- 

Please use the space below to record three concrete commitments that you are willing to make to your own health goals. For example you might commit "To arrive, ready to exercise, on Mondays, Wednesdays and Fridays by 6:30pm." These should be challenging but also realistic and attainable commitments. When finished, please sign this form to signify your personal commitment.

**Concrete Commitments to Reach Your Goals:**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. Time Commitment – # Days Per Week \_\_\_\_\_ # Minutes Per Day \_\_\_\_\_

Signed: \_\_\_\_\_ Witnessed: \_\_\_\_\_

**If you answered yes to any questions on page 2, please have your doctor complete the medical release form on the next page and return it to Abby Hipp before the initial meeting with a YMCA Personal Trainer.**

## Medical Release

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Dear Doctor:

Your patient \_\_\_\_\_ wishes to start a personalized training program through the Southeast YMCA Personal Training Program. Exercise recommendations provided by the trainer will start easy

and become progressively more intense depending on the client's goal and fitness level. Qualified staff will administer all fitness assessments and exercise.

If you know of any medical or other reasons why participation in the program by the client would be unwise, please indicate so on this form.

\_\_\_\_\_

**Report of Physician**

\_\_\_\_\_ I know of no reason why the applicant may not participate.

\_\_\_\_\_ I believe the client can participate, but I urge caution because:

\_\_\_\_\_  
\_\_\_\_\_

\* My patient is taking medications that will effect heart rate response to exercise.

The effects are indicated below:

Type of medication \_\_\_\_\_

Effect \_\_\_\_\_

Restrictions for exercise \_\_\_\_\_

\_\_\_\_\_ The client should not engage in the following activities:

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_ I recommend that the client NOT participate.

Physician Signature: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Print Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Thank You.      Please Fax To: 502.495.6607 Attn: Abby Hipp