

Y(our) Time Personal Training Procedures

I am extremely grateful that you have chosen Lisa Mandal Fitness to partner with in your fitness journey. The purpose of the Y(our) Time Personal Training program is to offer an individualized and affordable approach to training. Whether you live in the Boulder Colorado area or half way around the world, we are able to train together. Y(our) Time Personal Training offers you customized workouts that take into account your fitness level, health history, injury history, interests and goals. Remote Personal Training offers anytime email access to your trainer along with monthly face-to-face, phone or Skype assessments.

Lisa Mandal Fitness understands the time commitment needed to achieve fitness. That's why Lisa Mandal Fitness offers a way for you to get meaningful workouts on YOUR schedule.

Lisa Mandal Fitness Y(our) Time Personal Training program is a great way to receive quality ongoing assessment, programming, motivation and support at a fraction of the price of traditional personal training. Lisa Mandal Fitness will listen to and incorporate your training desires along with expert recommendations which include training periodization in order to maximize fitness and wellness gains. Here's how it works:

- 1) Client completes all paperwork in the New Client Y(our) Time Personal Training Packet and returns to Lisa Mandal Fitness. This includes video, as needed, of requested dynamic movements.
- 2) Lisa Mandal Fitness will thoroughly assess the information submitted by the client. Within one week, your trainer will contact you to set up an initial face-to-face, phone or Skype meeting. During this meeting you and your trainer will discuss fitness history, current and past health/medical issues, goals and any questions you have.
- 3) Lisa Mandal Fitness will provide you with your customized 4 week training program via email. Your programming will reflect your current fitness level, interests, available training equipment, desired time commitment and overall goals. If you are not a face-to-face client you will also receive links to videos explaining any training movements that may be unknown to you.
- 4) Over the next 4 weeks you will have email access to your trainer in the event you have any questions during your training. Upon completion of your 4 week training program you and your trainer will meet face-to-face, over the phone or via Skype to discuss your success over the past 4 weeks along with training goals for the next 4 weeks.
- 5) You will receive your next 4 weeks of programming. This pattern will continue as long as you choose to continue with the Y(our) Time Personal Training program.
- 6) Please let me know if you have any questions regarding the Y(our) Time Personal Training program. I am happy to answer any questions. I am completely confident in this training program and look forward to helping you achieve your fitness goals.

Sincerely,
Lisa Mandal, NASM-CPT, MSW

lisamandalfitness.com
info@lisamandalfitness.com
phone 303.736.9752

Health History

Name: _____

Address: _____

Phone: _____

Email: _____

Birthdate: _____ Age: _____

Gender: _____

Primary Healthcare Provider: _____

Phone: _____

Address: _____

1) Please circle all the conditions you have currently or have had in the past:

Heart Attack Asthma Stroke Chest Discomfort

Heart Murmur Trouble Sleeping Headaches Hernia

Neck Problems Back Problems Broken Bones

Surgeries Shortness of breath Swelling of Joints

Arthritis Anemia Thyroid Condition Epilepsy Fatigue

Anxiety or Depression Stomach Problems Limited Range of Motion

History of Heart Problems in immediate family

Please explain any conditions that you circled (i.e., treatment, symptoms, restrictions): _____

2) Do you currently smoke or did you quit smoking within the last 6 months?

Yes or No

If yes, how often do you smoke or how long ago did you quit?

3) Do you drink alcohol? Yes or No

If yes, how much and what type of alcohol do you drink?

4) Have you been diagnosed with high or low blood pressure by your doctor? Yes or No

If yes, what were the last three readings? ____/____; ____/____; ____/____

5) Have you been told you have high cholesterol by a doctor? Yes or No

If yes, then please list cholesterol levels and any interventions currently being used to manage your cholesterol:

6) Are pregnant or post-partum? Yes or No

If yes, then how far along in your pregnancy are you or how long ago did you give birth?

7) Do you have any joint or orthopedic problems? Yes or No

If yes, then what are the specifics?

8) Do have Diabetes? Yes or No

If yes, then please give details (e.g., Type, method of control):

9) Are you currently experiencing any pain? Yes or No

If yes, where is the pain? How long has it existed? Have you seen a health professional for treatment or assessment?

10) Are you taking any medications, prescribed or over-the-counter? Yes or No

If yes, please specify (name, dose, who prescribed, indication, when started, adherence):

11) When were you last seen by a physician?

12) Have you ever been advised NOT to exercise by a physician? Yes or No
If yes, then please explain:

13) Are there any other medical conditions or problems (past or present) not previously mentioned in this form that we should know about, or that may affect your ability to begin an exercise program? If yes, please explain:

Lifestyle Questionnaire

Name: _____

Age: _____

Height: _____

Weight: _____

Check one:

- 1) _____ I currently exercise
_____ I do not currently exercise and have never exercised regularly in the past
_____ I used to be active but am not anymore

If you do currently exercise, list those activities in which you participate and how much time you spend doing each per week: _____
_____.

If you do not currently exercise, why not? (barriers, unsure of what to do, etc.): _____
_____.

2) List any exercise, sport or physical activities in which you have participated:

a) In the past six months: _____

b) In the past 5 years: _____

3) How much time are you willing to devote to an exercise program?

Minutes per day: _____

Days per week: _____

4) Where will you be working out (a gym, in your home, outside):

_____.

5) If anywhere other than fully equipped gym, list specifically what exercise equipment you have access to:

_____.

Please use the following scale to answer questions 6) and 7):

1 2 3 4 5 6 7 8 9 10
 Not at all Somewhat Extremely

6) Rate the importance of each of the following exercise benefits to you:

<input type="checkbox"/> Improve cardiovascular functioning	<input type="checkbox"/> Improve flexibility
<input type="checkbox"/> Increase muscular strength	<input type="checkbox"/> Improve balance
<input type="checkbox"/> Body fat/weight loss	<input type="checkbox"/> Increase energy
<input type="checkbox"/> Improve performance for a specific sport	<input type="checkbox"/> Decrease stress
<input type="checkbox"/> Improve mood/feel better	<input type="checkbox"/> Enjoyment
<input type="checkbox"/> Improve speed, agility and power	<input type="checkbox"/> Increase bone density
<input type="checkbox"/> Other _____.	

7) Rate your interest in each of the following types of physical activity:

<input type="checkbox"/> Free weights/Dumbbells	<input type="checkbox"/> Running	<input type="checkbox"/> Yoga
<input type="checkbox"/> Weight machines	<input type="checkbox"/> Swimming	<input type="checkbox"/> Dance
<input type="checkbox"/> Cardio equipment	<input type="checkbox"/> Cycling	<input type="checkbox"/> Martial arts
<input type="checkbox"/> Group fitness classes	<input type="checkbox"/> Walking	<input type="checkbox"/> Team Sports
<input type="checkbox"/> Interval training	<input type="checkbox"/> Core work	<input type="checkbox"/> Functional training
<input type="checkbox"/> Other _____.		

8) How many meals/snacks do you have per day?

_____.

9) Do you feel you eat healthy most of the time? Yes No

Please check all that apply:

I pursue a diet that is high in unprocessed foods

I eat at least 5 servings of fruits/vegetables a day

I almost always eat a full, healthy breakfast

I rarely eat high sugar or high fat desserts

I seldom consume red meats

10) How many 8 ounce glasses of water do you drink a day?

0-2 3-5 6-8 9-12 >12

11) How much sleep, on average, do you get a night?

_____.

12) On a scale of 1-10, 10 being the highest, how much stress would you say you are currently experiencing? _____

13) Please list your main stressors?

14) What is your occupation? _____
How many hours do you work a week? _____.

15) Please write down your primary health/fitness goal for the next:

- a) 1 month: _____
- b) 1 year: _____

16) How will you know that you are successful in reaching your goals?
(Please rank most important to least important, 1 being most important, 5 being least).

- a) Improved functional ability (I am better at my sport, I can run faster, I can lift heavier amounts of weight, I have less back pain, etc.) _____
- b) I weigh less or have smaller BMI _____
- c) My clothes fit better _____
- d) I feel better about myself/have more energy _____
- e) I decrease my risk factors for disease (My cholesterol goes down, I don't need blood pressure medicine, my bone density is increased, etc.) _____

17) Why are you choosing the Y(our) Time Personal Training program to get healthy?

Please list any additional information that you would like Lisa Mandal Fitness to know about you before getting started (effective motivation techniques for you, exercises you love/hate, hesitations about beginning a program, etc.): _____

PAR-Q

(Physical Activity Readiness Questionnaire)

Print Name: _____

Date of Birth: ____/____/____

If you are planning to become more physically active than you are now, start by answering the seven questions below. If you are between the ages of 15-69, the PAR-Q will tell you if you should check with your doctor before you start. If you are over 69 years of age and you are not used to being active, check with your doctor.

- 1) Has your doctor ever said that you have a heart condition and that you should only do physical activity recommended by your doctor? Yes No
- 2) Do you feel pain in your chest when you do physical activity? Yes No
- 3) In the past month, have you had chest pain when you were doing physical activity? Yes No
- 4) Do you lose your balance because of dizziness or do you ever lose consciousness? Yes No
- 5) Do you have a bone or joint problem that could be made worse by a change in your physical activity? Yes No
- 6) Is your doctor currently prescribing drugs (for example, water pills) for your blood pressure or heart condition? Yes No
- 7) Do you know of any other reason why you should not do physical activity? Yes No

If you answered yes to one or more of the questions, please talk with your doctor by phone or in person BEFORE you start becoming more physically active or BEFORE you have a fitness assessment. Tell your doctor about the PAR-Q and which questions you answered YES.

If you answered NO to all questions, you can be reasonably sure that you can safely start an appropriate exercise program.

If your health changes so that you answer YES to any of the above questions, tell your health professional. Ask whether you should change your physical activity plan. If in doubt, consult your physician prior to physical activity.

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

Signature: _____

Date: ____/____/____

Medical Release Form

*If you answered "yes" to any of the questions on the PAR-Q form it is required that you have a Medical Release completed by your physician before Lisa Mandal Fitness begins any further regimen with you.

*Lisa Mandal Fitness may also require that a Medical Release form be completed before beginning any fitness regimen with you if your health history indicates any higher risk conditions. If necessary, this will be discussed in greater detail during your initial assessment.

Please use your browser to print this page. Have it filled out by you and your physician and then return it to me.

Dear Doctor:

Your patient, _____, wishes to start a personalized fitness program with Lisa Mandal Fitness.

The activity will involve, but is not limited to: regular cardiorespiratory activity and regular resistance training which will elevate his/her heart rate, blood pressure, respiratory rate and general oxygen consumption.

If your patient is taking medication that will affect his/her physiological response to exercise, please indicate the manner (e.g., raises, lowers heart rate or blood pressure):

Type(s) of medication(s):

Effect(s): _____

Please identify any other recommendations or restrictions for your patient in this exercise program:

Thank You,

Lisa Mandal. NASM-CPT, MSW

303.736.9752

info@lisamandalfitness.com

_____ has my
approval to begin an exercise program with the recommendations or restrictions stated
above.

Printed name: _____ Phone: _____

Signed: _____ Date: ____/____/____

Consent Form

I acknowledge that I am in good health, have answered the Y(our) Time Personal Training program questions truthfully and have no known medical problems that would restrict my ability to participate in this exercise program.

Participant name

(printed): _____

Participant

signature: _____

Date: ____/____/____

Liability Release

1) In consideration of being allowed to participate in personal fitness training activities and programs of Lisa Mandal Fitness, LLC and to use its facilities, equipment and services, in addition to the payment of any fee or charge, I do hereby forever waive, release and discharge Lisa Mandal Fitness, LLC and its officers, agents, employees, representatives, executors and all others acting on their behalf from any and all claims or liabilities for injuries or damages to my person and/or property, including those caused by the negligent act or omission of any of those mentioned or others acting on their behalf, arising out of or connected with my participation in any activities, programs or services of Lisa Mandal Fitness, LLC or the use of any equipment at various sites, including home, provided by and/or recommended by Lisa Mandal Fitness, LLC. (Please Initial: _____).

2) I have been informed of, understand and am aware that strength, flexibility and aerobic exercise, including the use of equipment, is a potentially hazardous activity. I also have been informed of, understand and am aware that fitness activities involve a risk of injury, including a remote risk of death or serious disability, and that I am voluntarily participating in these activities and using equipment and machinery with full knowledge, understanding and appreciation of the dangers involved. I hereby agree to expressly assume and accept any and all risks of injury or death. (Please Initial: _____).

3) I do hereby further declare myself to be physically sound and suffering from no condition, impairment, disease, infirmity or other illness that would prevent my participation in these activities or use of equipment or machinery. I do hereby acknowledge that I have been informed of the need for a physician's approval for my participation in the exercise activities, programs and use of exercise equipment. I also acknowledge that it has been recommended that I have a yearly or more frequent physical examination and consultation with my physician as to physical activity, exercise and use of exercise equipment. I acknowledge that either I have had a physical examination and have been given my physician's permission to participate or I have decided to participate in the exercise activities, programs and use of equipment without the approval of my physician and do hereby assume all responsibility for my participation in said activities, programs and use of equipment. (Please Initial: _____).

4) I understand that Lisa Mandal Fitness, LLC providing and maintaining an exercise/fitness program for me does not constitute an acknowledgment, representation or indication of physiological well-being or medical opinion relating thereto. Further, I understand that Lisa Mandal Fitness Y(our) Time Personal Training program will involve myself doing exercises without immediate supervision of

the activity. I acknowledge that it is my responsibility to monitor my safety during exercise and to stop and seek medical attention if needed. (Please Initial: _____).

Date: _____

Signature: _____

Printed Name: _____

Trainer's Signature: _____