Personal Training Information Form

Personal Training is available to all members and all sessions are 1 hour in length. To register: Please complete the Personal Training Information form. You will be contacted via phone or e-mail to choose a trainer and purchase a package of your choice.

Client Information

Contact Information [Required]
Valid input:
- must be 10-15 digits long and may include only numbers, hyphens, and spaces.
- name@myschool.edu

First name:
Middle initial:
Last name:
Email address:
Phone number:
Address:
City:
State:
ZIP:

Date of Birth: [Required]
Valid input:
- Numeric - ex: 1111

Physician's Name | Physican's Phone | Physican's Fax

History of Physical Activity

IN THE PAST 3 MONTHS HOW OFTEN DID YOU PARTICIPATE IN PHYSICAL ACTIVTY? [Required]
Valid input:
- Select only one choice.
- must select a value.

[ ] Regulary (3-4 times/week)
[ ] Semi-Regulary (1-2 times/week)
[ ] Sporadic (1-2 times/week)
[ ] Not At All

PLEASE DESCRIBE THE ACTIVITES YOU HAVE BEEN DOING:
Valid input:
- Alpha - ex: AAaa
- must be between 3 and 100 characters.

WHAT ARE YOUR PERSONAL BARRIERS TO EXERCISE?
Reasons why you do not exercise.

HAVE YOU WORKED WITH A PERSONAL TRAINER BEFORE? [Required]
Valid input:
- Select only one choice.

[ ] YES
[ ] NO

DO YOU HAVE A PERSONAL TRAINER PREFERENCE?

[ ] Male
[ ] Female

Training Expectations:

Monday through Sunday Availability
Please provide the days and times you would be available to train.

Physical Activity Rediness Questionare

PAR- Q Risk Factors

Are you a man over the age of 45 or a woman over the age of 55? [Required]
Valid input:
- Select only one choice.

[ ] Man over the age of 45
[ ] Woman over the age of 55
[ ] None of the above

Has your father or brother experienced a heart attack before age 55 or has your mother or sister experienced a heart attack before age 65? [Required]
Valid input:
- Select only one choice.

[ ] Father/brother before age 55
[ ] Mother/sister before age 65
[ ] None of the above

Do you currently smoke? [Required]
Valid input:
- Select only one choice.

[ ] Yes
[ ] No

Have you quit smoking in the last 6 months? [Required]
Valid input:
- Select only one choice.

[ ] Yes
[ ] No

Are you physically inactive? (Less than 30 minutes a day at least 3 days per week) [Required]
Valid input:
- Select only one choice.

[ ] Yes
[ ] No

Are you more than 20 lbs overweight or Do you have a BMI of more than 30? [Required]

[ ] More than 20lbs overweight
[ ] BMI greater than 30
[ ] Neither Apply

Is your waist circumference >40 inches (men) or Is your waist circumference >35 inches (women)? [Required]
Valid input:
- Select only one choice.

[ ] Waist Circumference >40 in (Men)
[ ] Waist Circumference >35 in (Women)
[ ] Neither Apply

Has your physcian ever told you that you might have high blood pressure? > 140/90 [Required]
Valid input:
- Select only one choice.

[ ] Yes
[ ] No

Do you have cholesterol >200 mg/dl? LDL>130 mg/dl? HDL<40 mg/dl? [Required]

[ ] Cholesterol >200 mg/dl
[ ] LDL >130 mg/dl
[ ] HDL <40 mg/dl
[ ] None of the above apply

Do you have impared fasting glucose >100 mg/dl, but <126 mg/dl or Do you have impared glucose tolerance >140 mg/dl, but <200 mg/dl? [Required]

[ ] Impared Fasting Glucsose >100 mg/dl, but126 mg/dl
[ ] Impared Glucose Tolerance >140 mg/dl, but <200 mg/dl
[ ] Not sure
[ ] None of the above apply

Is your HDL >60 mg/dl? [Required]
Valid input:
- Select only one choice.

[ ] Yes
[ ] No
[ ] Not sure

If you check tow or more of the risk factors listed above, we will ask you to consult a physcian prior to participating in any physical activity including completing an assessment.

Par-Q History & Symptoms

Have you had: [Required]
Please check all that apply

[ ] Heart Attack
[ ] Heart Surgery
[ ] Heart Catheterization
[ ] Heart Angioplasty (PTCA)
[ ] Implanted Pacemaker or Defibrillator
[ ] Heart Valve Disease
[ ] Heart Failure
[ ] Heart Transplant
[ ] Congenital Heart Disease

If you check anyh of these statements we ask that you consult a physician prior to participating in any physical activity including competing an assessment.

Has your doctor ever said that you have a heart condition and that you should only do physical activity recommended by a doctor? [Required]
Valid input:
- Select only one choice.

[ ] Yes
[ ] No

Do you feel pain in your chest when you do physical activity? [Required]
Valid input:
- Select only one choice.

[ ] Yes
[ ] No

In the past month, have you had chest pain when you were not doing phsycial activity? [Required]
Valid input:
- Select only one choice.

[ ] Yes
[ ] No

Do you lose your balance because of dizziness? [Required]
Valid input:
- Select only one choice.

[ ] Yes
[ ] No

Do you ever lose consciousness? [Required]
Valid input:
- Select only one choice.

[ ] Yes
[ ] No

Do you have a bone or joint problem that could be made worse by a change in your phsycial activity? [Required]
Valid input:
- Select only one choice.

[ ] Yes
[ ] No

Is your doctor currently prescribing drugs fr yoru blood pressure or heart condition? [Required]
Valid input:
- Select only one choice.

[ ] Yes
[ ] No

Do you know of any other reason why you should not do physical activty? [Required]
Please list reasons why if the answer is yes, or write doesn't apply.

If you check yes to any of these statements we ask that you consult a physician prior to participating in any physical activity including completing an assessment.

Personal Fitness & Wellness Goals

What is your fitness and wellness goal? [Required]

Why did you pick this goal? [Required]

What is your timeline to achieve your goal? [Required]

On a scale of 1-10, how determined are you to achieve your goal? [Required]

What barriers or obstacles might prevent you from achieving your goals? [Required]

Once achieved, how will you celebrate reaching your goal? [Required]