



# FitnessPro

Private 1-on-1 Personal Training

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

1. In consideration of being allowed to participate in the personal exercise, weight training and fitness testing activities of FitnessPro and to use the equipment and machinery of FitnessPro, in addition to the payment of any fee or charge, I,

\_\_\_\_\_

do hereby waive, release and forever discharge FitnessPro, its officers, agents, employees, representatives, executors and all others from any and all responsibilities or liabilities from injuries or damages resulting from my participation in said fitness activities or my use of said equipment and machinery. I do also hereby release all of those mentioned and any others acting on their behalf from any responsibilities or liabilities for any injury or damage to myself, including those caused by the negligent act or omission of any of those mentioned or others acting in their behalf arising out of or connected in any way with my participation in the fitness programs or activities of FitnessPro, or the use of the equipment and machinery of FitnessPro.

(Please initial \_\_\_\_\_)

2. I understand and am aware that strength, flexibility and aerobic exercise, including the use of cardiovascular and weight training and machinery, is a potentially hazardous activity. I also understand that fitness activities involve a risk of injury and even death, and that I am voluntarily participating in these activities and using the equipment and machinery with knowledge of the dangers involved. I hereby agree to expressly assume and accept 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 the activities or programs of FitnessPro, or my use of the equipment and machinery except as hereinafter stated. I do hereby acknowledge that I have been informed of the need for a physician's approval for my participation in the personal exercise, weight training and fitness testing activities of FitnessPro, or in the use of exercise and weight training equipment and machinery. 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 activities, exercise and the use of exercise and weight training equipment and machinery so that I might have his/her recommendations concerning these fitness activities and equipment/machinery use. I acknowledge that I have either had a physical examination and have been given my physicians permission to participate, or that I have decided to participate without the approval of my physician and do hereby assume all responsibility for my participation and utilization of equipment and machinery in my personal exercise, weight training and fitness testing activities.

(Please initial \_\_\_\_\_)

Signature

Date

# Client Data Questionnaire

This information will help us to track your progress with our facility. Please answer each of these questions as accurately as you can. Should you have any questions, feel free to ask. Your responses will be treated in a confidential manner.

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

Sex: Male Female (Circle one)

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

Address: \_\_\_\_\_

City: \_\_\_\_\_

Zip: \_\_\_\_\_ State: \_\_\_\_\_

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

Email Address: \_\_\_\_\_ Day Ph: \_\_\_\_\_ Mobile: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

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

# Informed Consent Form

**Assessment Objectives.** The assessment you are about to undergo is designed to give a reasonable measure of your current level of fitness, and will include the following (Check where appropriate):

- Aerobic Capacity
- Body Composition
- Lung Function
- Flexibility
- Muscular Strength
- Muscular Endurance

**Explanation of Procedures.** The tests will be explained to you by the member of staff and they will be pleased to answer any questions you may have. Certain pieces of specialized equipment will be used to perform the assessment, and you can stop the test at any point if you feel uncomfortable or unwell.

**Potential Risks.** Because of the nature of the assessment, a level of exertion is required. This exertion will cause temporary changes which will increase the heart rate and raise the blood pressure. This may place participants with cardiovascular or other disease – whether diagnosed or undiagnosed – at significant risk for adverse events or even death. In addition, as with all vigorous physical activity, there exists a risk musculoskeletal injury. Please note that while these outcomes are rare, it is quite common for participants to experience some stiffness in the muscles in the next few days after testing. Our staff are trained to perform assessments and first aid and will respond quickly to any problems.

**Potential Benefits.** Your assessment results will help to determine your present level of fitness, and highlight any areas of specific need. This will be particularly useful when designing an exercise program that will be personalized, safe, and effective.

**Consent.** I have read the information on this page and I understand it. Any questions concerning the information and procedures have been answered to my satisfaction. I also understand that I am free to stop the assessment at any time and seek professional medical advice or opinion.

Any information derived from the assessment is confidential and will not be disclosed without my permission to anyone other than my Doctor or the staff of this facility. However, I agree that information from the assessment not attributable to me may be used for research purposes and stored on an electronic database.

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

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

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

# PAR-Q and You

(A Questionnaire for People Aged 15 to 69)

Regular physical activity is fun and healthy, and more people are becoming more active every day. Being more active is very safe for most people. However, some people should check with their doctor before becoming much more physically active.

If you are planning to become much more physically active than you are now, start by answering the seven questions in the box below. If you are between the ages of 15 and 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 very active, check with your doctor.

Common sense is your best guide when you answer these questions. Please read the questions carefully and answer each one honestly: check YES or NO.

- Has your doctor ever said that you have a heart condition and that you should only do physical activity recommended by a doctor?
- Do you feel pain in your chest when you do physical activity?
- In the past month, have you had chest pain when you were not doing physical activity?
- Do you lose your balance because of dizziness or do you ever lose consciousness?
- Do you have a bone or joint problem that could be made worse by a change in your physical activity?
- Is your doctor currently prescribing drugs (for example, water pills) for your blood pressure or heart condition?
- Do you know of any other reason why you should not do physical activity?

**If you answered YES to one or more questions,** talk with your doctor by phone or in person BEFORE you start becoming much more physically active or BEFORE you have a fitness appraisal. Tell your doctor about the PAR-Q and which questions you answered YES. You may be able to do any activity you want - as long as you start slowly and build up gradually. Or, you may need to restrict your activities to those that are safe for you. Talk with your doctor about the kinds of activities you wish to participate in and follow his/her advice.

**If you answered NO honestly to all questions, you can be reasonably sure that you can:**

- Start becoming much more physically active - begin slowly & build up gradually. This is the safest & easiest way to go.
- Take part in a fitness appraisal - this is an excellent way to determine your basic fitness so that you can plan the best way for you to live actively.

**Even if you answered no to all questions, you should delay becoming much more active:**

- If you are not feeling well because of a temporary illness such as a cold or a fever - wait until you feel better.
- If you are or may be pregnant - talk to your doctor before you start becoming more active.

Please note: If your health changes so that you then answer YES to any of the above questions, tell your fitness or health professional. Ask whether you should change your physical activity plan.

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

Name: \_\_\_\_\_.

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

Signature of Parent: \_\_\_\_\_ Witness: \_\_\_\_\_  
or Guardian (for participants under the age of majority)

# Medical/Health Status Questionnaire

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On this questionnaire, a number of questions regarding your physical health are to be answered. Please answer every question as accurately as possible so that a correct assessment can be made. Please place a check in the space to the left of the question to answer "Yes." Leave blank if your answer is "No." Please ask if you have any questions. Your responses will be treated in a confidential manner.

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

## Medical Screening

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- Do you have any personal history of heart disease (coronary or atherosclerotic disease)?
  - Any personal history of diabetes or other metabolic disease (thyroid,renal,liver)?
  - Any personal history of pulmonary disease, asthma, interstitial lung disease or cystic fibrosis?
  - Have you experienced pain or discomfort in your chest apparently due to blood flow deficiency?
  - Any unaccustomed shortness of breath (perhaps during light exercise)?
  - Have you had any problems with dizziness or fainting?
  - Do you have difficulty breathing while standing or sudden breathing problems at night?
  - Have you experienced a rapid throbbing or fluttering of the heart?
  - Do you suffer from ankle edema (swelling of the ankles)?
  - Have you experienced severe pain in leg muscles during walking?
  - Do you have a known heart murmur?
  - Has your serum cholesterol been measured at greater than 200 mg/dl?
  - Has your HDL (the "good" cholesterol) been measured at greater than 60 mg/dl?
  - Are you a cigarette smoker?
  - Would you characterise your lifestyle as "sedentary"?
  - Have you had a high fasting blood glucose level on 2 or more occasions ( $\geq 110$ mg/dl)?
  - Are you 20% or more overweight or have you been told your "BMI" was greater than 30?
  - Have you been assessed as hypertensive on at least 2 occasions (systolic  $> 140$  mmHg or diastolic  $> 90$ mmHg)?
  - Do you have any family history of cardiac or pulmonary disease prior to age 55?
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## Medical History - Detail

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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:

## Family History

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Have your mother, father, or siblings suffered from (please select all that apply):

- |  |  |
|--|--|
| <input type="checkbox"/> Heart attack or surgery prior to age 55.                  | <input type="checkbox"/> High cholesterol                    |
| <input type="checkbox"/> Stroke prior to age 50.                                   | <input type="checkbox"/> Diabetes                            |
| <input type="checkbox"/> Congenital heart disease or left ventricular hypertrophy. | <input type="checkbox"/> Obesity                             |
| <input type="checkbox"/> Hypertension  | <input type="checkbox"/> Asthma                              |
| <input type="checkbox"/> Osteoporosis  | <input type="checkbox"/> Leukemia or cancer prior to age 60. |
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## Medications

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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:

## Lifestyle

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Are you a cigarette smoker? If so, how many per day?

Previously a cigarette smoker? If so, when did you quit?

How many years have you smoked or did you smoke before quitting?

Do you/did you smoke (Circle one): Cigarettes    Cigars    Pipe

Please Rate Your Daily Stress Levels (select one):

Low     Moderate     High but I enjoy the challenge     High: sometimes difficult to handle     High: often difficult to handle.

Do you drink alcoholic beverages?

How many units of alcohol do you consume per week: \_\_\_\_\_ (see Alcohol Units Calculator below)

### Alcohol Units Table

Type of Drink	Units
½ pint of beer	1
1 glass of wine	1
1 pub measure of spirits (Gin, Vodka etc.)	1
1 can of beer	1.5
1 bottle of strong lager	2.5
1 can of strong lager	4
1 bottle of wine	7
1 litre bottle of wine	10
1 bottle of fortified wine (port, sherry etc.)	14
1 bottle of spirits	30

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

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

# Client Goals Questionnaire

Today's Date: \_\_\_\_\_ Your name: \_\_\_\_\_

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