PERSONAL TRAINING PACKET

Name: _____ Date: _____

WOODSON YMCA

Personal Training Packet

Name _____ Date _____

WAIVER

By signing this document, I acknowledge that I have been informed of the need to obtain a physician's examination and approval prior to beginning this exercise program. I fully understand that the program may be strenuous and choose to participate completely voluntarily. I accept all responsibility for my health and any resultant injury or mishap that may affect my wellbeing, or health in any way. I hold harmless of any responsibility, the instructor, facility, or any persons involved with this program or testing procedures.

Signature _____ Date _____

CANCELLATION POLICY

By signing this document, I acknowledge and understand that I must notify my personal trainer 24 hours in advance if I need to cancel a scheduled training session. If I do not provide 24 hours' notice, I will lose the session and will not be refunded.

Signature _____ Date _____

INFORMED CONSENT

By signing this document, I acknowledge that I have voluntarily chosen to participate in a program of progressive physical exercise, which can enhance the musculoskeletal and cardio respiratory systems. In signing this document, I acknowledge being informed of the possible strenuous nature of the program and the potential for unusual, but possible, physiological results including, but not limited to, abnormal blood pressure, fainting, heart attack, or death. By signing this document, I assume all risk for my health and well being and hold harmless of any responsibility, the instructor, facility, or any persons involved with this program and testing procedures. I understand that questions about exercise procedures and recommendations are encouraged and welcome.

Signature _____ Date _____

WOODSON YMCA

Health and Lifestyle Questionnaire

Please complete the information below.

First Name _____ Date _____

Address _____

Date of Birth _____ Age _____

Phone _____ Email _____

Employer / Occupation _____

How many hours do you work per week?

❑ < 35 ❑ 35–40 ❑ 40–45 ❑ 45–50 ❑ > 50

What are the primary physical requirements of your job?

❑ Phone ❑ Computer ❑ Sitting ❑ Standing ❑ Lifting ❑ Travel

Please rate your level of stress on the following scale, circle one.

Home:	Low Stress	1	2	3	4	5	High Stress
Work:	Low Stress	1	2	3	4	5	High Stress

Please list a relative whom we me may contact in case of an emergency.

Emergency Contact _____ Relation _____

Phone _____ Work Phone _____

Emergency Contact _____ Relation: _____

Phone _____ Work Phone _____

Please complete the information for your personal health care provider.

Name of Provider _____ Clinic Name _____

Address _____

Office Phone _____

Instructions: Please complete the entire questionnaire, responding to all requested information and providing as much detail as possible. Indicate "N/A" for those items that are not applicable.

WOODSON YMCA

Health and Lifestyle Questionnaire

Family Health History

Please indicate if you have any primary relatives who have any of the following conditions. (Check all that apply)

❑ Asthma ❑ Cancer ❑ Hypertension ❑ High Cholesterol ❑ Arthritis
❑ Diabetes ❑ Heart Disease ❑ Osteoporosis ❑ Obesity ❑ Stroke
❑ Other:_____

Please provide a brief explanation for any of the above that have been checked.

Personal Health History

Please indicate of you have any of the following conditions. (Check all that apply).

❑ Asthma ❑ Cancer ❑ Hypertension ❑ High Cholesterol ❑ Arthritis
❑ Diabetes ❑ Heart Disease ❑ Osteoporosis ❑ Obesity ❑ Stroke
❑ Other:_____

Please provide a brief explanation for any of the above that have been checked.

Please indicate if you have had any joint injuries or surgeries that may limit or effect your ability to exercise.

❑ Neck ❑ Hip ❑ Wrist/Hand ❑ Shoulder ❑ Knee
❑ Ankle/Foot ❑ Elbow ❑ Low Back ❑ Other _____

Please provide a brief explanation for any of the above that have been checked.

WOODSON YMCA

Health and Lifestyle Questionnaire

Please indicate any medications currently used.

Type of Medication	Purpose
_____	_____
_____	_____
_____	_____
_____	_____

Do you smoke cigarettes? ❑ Yes ❑ No

If yes, how often? _____

Are you a past smoker? ❑ Yes ❑ No

If yes, when did you quit? _____

Do you drink alcoholic beverages? ❑ Yes ❑ No

If yes, when did you quit? _____

Are you presently dieting or on a weight control program? ❑ Yes ❑ No

If yes, please provide a brief explanation.

_____

_____

_____

_____

Do you have any past or present medical conditions, not already addressed, which may influence your ability to safely participate in an exercise program? If yes, please explain.

_____

_____

_____

_____

Please provide a brief explanation of your current exercise program. Include types of activity and frequency.

_____

_____

_____

_____

WOODSON YMCA

Health and Lifestyle Questionnaire

What are your current health and fitness goals? Please be specific as possible.

Do you foresee any barriers that may prevent you from adhering to a regular exercise program?

How do you rate your level of motivation and commitment to achieving your goals? Circle one.

Low 1 2 3 4 5 High

Have you worked with a personal trainer? ❑ Yes ❑ No

When are you available to meet with a trainer?

- ❑ Morning
- ❑ Day
- ❑ Evening
- ❑ Other: _____

Do you prefer to work with a male or female trainer?

- ❑ Male
- ❑ Female
- ❑ No preference

How did you hear about our Personal Training Services?

- ❑ Flyer
- ❑ Referral from friend
- ❑ Staff
- ❑ Website
- ❑ Other: _____

2022 PAR-Q+

The Physical Activity Readiness Questionnaire for Everyone

The Physical Activity Readiness Questionnaire for Everyone

The health benefits of regular physical activity are clear; more people should engage in physical activity every day of the week. Participating in physical activity is very safe for MOST people. This questionnaire will tell you whether it is necessary for you to seek further advice from your doctor OR a qualified professional before becoming more physically active.

General Health Questions

Please read the 7 questions below carefully and answer each one honestly: Check YES or NO

1.	Has your doctor ever said that you have a heart condition or high blood pressure?	❑ Yes ❑ No
2.	Do you feel pain in your chest, during your daily activities of living, OR when you do physical activity?	❑ Yes ❑ No
3.	Do you lose balance because of dizziness OR have lost consciousness in the last 12 months? Please answer NO if your dizziness was associated with over-breathing (including during vigorous exercise).	❑ Yes ❑ No
4.	Have you ever been diagnosed with another chronic medical condition? Please list conditions here:	
5.	Are you currently taking prescribed medications for a chronic medical condition? Please list conditions/medications here:	
6.	Do you currently have (or have had within the past 12 months) a bone, joint, or soft tissue (muscle, ligament, or tendon) problem that could be made worse by becoming more physically active? Please answer NO if you had a problem in the past, but it does not limit your current ability to be physically active. Please list conditions here:	❑ Yes ❑ No
7.	Has your doctor ever said that you should only do medically supervised physical activity? If you answered NO to all the questions above, you are cleared for physical activity.	❑ Yes ❑ No

Please sign the PARTICIPANT DECLARATION. You do not need to complete Pages 2 and 3.

- Start becoming more physically active-start slowly and build up gradually
- Follow International Physical Activity Guidelines for your age (www.who.int/dietphysicalactivity/en/).
- You may take part in health and fitness appraisal.
- If you are over the age of 45 years old and NOT accustomed to regular vigorous to maximal effort exercise, consult a qualified exercise professional before engaging in this intensity of exercise.

PARTICIPANT DECLARATION

If you are less then the legal age required for consent or require the assent of a care provider, your parent, guardian or care provider must also sign this form.

I, the undersigned, have read, understood to my full satisfaction and completed this questionnaire. I acknowledge that this physical activity clearance is valid for a maximum of 12 months from the date it is completed and becomes invalid if my condition changes. I also acknowledge that the community/fitness center may retain a copy of this form for records. In these instances, it will maintain the confidentiality of the same, complying with applicable law.

Name _____ Date _____

Signature _____ Date _____

Witness _____ Date _____

Signature of Parent/Guardian/Care Provider: _____ Date _____

IF YOU ANSWERED YES TO ONE OR MORE OF THE QUESTIONS ABOVE, COMPLETE PAGES 2 & 3.

DELAY BECOMING MORE ACTIVE IF...

- You have temporary illness such as cold or fever; it is best to wait until you feel better.
- You are pregnant- talk to your health care practitioner, your physician, a qualified exercise professional, and/or complete the ePARmed-x+ at www.eparnmedx.com before becoming more physically active.
- Your health changes- answer the questions on pages 2 & 3 of this document and/or talk to your doctor or a qualified exercise professional before continuing with any physical activity program.

2022 PAR-Q+

The Physical Activity Readiness Questionnaire for Everyone

FOLLOW UP QUESTIONS ABOUT YOUR MEDICAL CONDITION(S)

1.	Do you have Arthritis, Osteoporosis, or Back Problems? • If the above condition(s) is/are present, answer a-c • If NO go to question 2	❑ Yes ❑ No
1a.	Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? Answer NO if you are not currently taking medications or other treatments.	❑ Yes ❑ No
1b.	Do you have joint problems causing pain, a recent fracture or fracture caused by Osteoporosis or cancer, displaced vertebra (e.g. spondylolisthesis), and/or spondylolisthesis/pars defect (a crack in the bony ring on the back of the spinal column)?	❑ Yes ❑ No
1c.	Have you had steroid injections or taken steroid tablets regularly for more than 3 months?	❑ Yes ❑ No
2.	Do you currently have cancer of any kinds? • If the above condition(s) is/are present, answer questions a-b. • If NO, go to question 3	❑ Yes ❑ No
2a.	Does your cancer diagnosis include any of the following types: Lung/bronchogenic, multiple myeloma (cancer of plasma cells), head, and/or neck?	❑ Yes ❑ No
2b.	Are you currently receiving cancer therapy (such as chemotherapy or radiotherapy)?	❑ Yes ❑ No
3.	Do you have a Heart or Cardiovascular Condition? (This includes Coronary Artery Disease, Heart Failure, Diagnosed Abnormality of Heart Rhythm). • If the above condition(s) is/are present, answer a-d. • If NO, go to question 4.	❑ Yes ❑ No
3a.	Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (answer NO if you are not currently taking medications or other treatments).	❑ Yes ❑ No
3b.	Do you have an irregular heart beat that requires medical management? (e.g., atrial fibrillation, premature ventricular contraction).	❑ Yes ❑ No
3c.	Do you have chronic heart failure?	❑ Yes ❑ No
3d.	Do you have diagnosed coronary artery (cardiovascular) disease and have not participated in regular physical activity in the last 2 months?	❑ Yes ❑ No
4.	Do you have high blood pressure? • If the above condition(s) is/are present , answer questions a-b. • If NO, go to question 5	❑ Yes ❑ No
4a.	Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer NO if you are not currently taking medications or other treatments).	❑ Yes ❑ No
4b.	Do you have resting blood pressure equal to or greater than 160/90 mmHg with or without medication? (Answer YES if you do not know your testing blood pressure).	❑ Yes ❑ No
5.	Do you have any Metabolic Conditions? (This includes Type 1 Diabetes, Type 2 Diabetes, Pre-Diabetes). • If the above condition(s) is/are present, answer questions a-e. • If NO, go to question	❑ Yes ❑ No
5a.	Do you often have difficulty controlling your blood sugar levels with foods, medications, or other physician-prescribed therapies?	❑ Yes ❑ No
5b.	Do you often suffer from signs and symptoms of low blood sugar (Hypoglycemia) following exercise and/or during activities or daily living? (Signs of hypoglycemia may include shakiness, nervousness, unusual irritability, abnormal sweating, dizziness or light-headedness, mental confusion, difficulty speaking, weakness, or sleepiness.)	❑ Yes ❑ No
5c.	Do you have any signs or symptoms of diabetes complications such as heart or vascular disease and/or complications affecting your eyes, kidneys, OR the sensation in your toes and feet?	❑ Yes ❑ No
5d.	Do you have other metabolic conditions (such as current pregnancy-related diabetes, chronic kidney disease, or liver problems)?	❑ Yes ❑ No
5e.	Are you planning to engage in what for you is unusually high (or vigorous) intensity exercise in the near future?	

2022 PAR-Q+

The Physical Activity Readiness Questionnaire for Everyone

6. Do you have any Mental Health Problems or Learning Difficulties? (This includes Alzheimer's, Dementia, Depression, Anxiety Disorder, Eating Disorder, Psychotic Disorder, Intellectual Disability, and Down Syndrome). • If the above medical condition(s) is/are present, answer questions a-b. • If NO, go to question 7.	❑ Yes ❑ No
6a. Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer NO if you are not currently taking medications or other treatments).	❑ Yes ❑ No
6b. Do you have Down Syndrome AND back problems affecting nerves or muscles?	❑ Yes ❑ No
7. Do you have Respiratory Disease? (This includes Chronic Obstructive Pulmonary Disease, Asthma, Pulmonary High Blood Pressure). • If the above condition(s) is/are present, answer questions a-d. • If NO, go to question 8.	❑ Yes ❑ No
7a. Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer NO if you are not currently taking medications or other treatments).	❑ Yes ❑ No
7b. Has your doctor said your blood oxygen level is low at rest or during exercise and/or that you require supplemental oxygen therapy?	❑ Yes ❑ No
7c. If asthmatic, do you currently have symptoms of chest tightness, wheezing, labored breathing, consistent cough (more than 2 days/week), or have you used your rescue medication more than twice in the last week?	❑ Yes ❑ No
7d. Has your doctor ever said you have high blood pressure in the blood vessels of your lungs?	❑ Yes ❑ No
8. Do you have a Spinal Cord Injury? (This includes Tetraplegia and Paraplegia). • If the above condition(s) is/are present, answer questions a-c • If NO, go to question 9.	❑ Yes ❑ No
8a. Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer NO if you are not currently taking medications or other treatments).	❑ Yes ❑ No
8b. Do you commonly exhibit low resting blood pressure significant enough to cause dizziness, light-headedness, and/or fainting?	❑ Yes ❑ No
8c. Has your physician indicated that you exhibit sudden bouts of high blood pressure (known as Autonomic Dysreflexia)?	❑ Yes ❑ No
9. Have you had a Stroke? (This includes Transient Ischemic Attack (TIA) or Cerebrovascular Event). • If the above condition(s) is/are present, answer questions a-c • If NO, go to question 10.	❑ Yes ❑ No
9a. Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer NO if you are not currently taking medications or other treatments).	❑ Yes ❑ No
9b. Do you have any impairment in walking or mobility?	❑ Yes ❑ No
9c. Have you experienced a stroke or impairment in nerves of muscles in the past 6 months?	❑ Yes ❑ No
10. Do you have any other medical conditions not listed above or do you have two or more medical conditions? • If you have any other medical conditions, answer questions a-c. • If NO, read the Page 4 recommendations	❑ Yes ❑ No
10a. Have you experienced a blackout, fainted, or lost consciousness as a result of a head injury within the last 12 months OR have you had a diagnosed concussion within the last 12 months?	❑ Yes ❑ No
10b. Do you have a medical condition that is not listed (such as epilepsy, neurological conditions, kidney problems)?	❑ Yes ❑ No
10c. Do you currently live with two or more medical conditions?	❑ Yes ❑ No
Please list your medical condition(S) and any related medications here:	

GO TO PAGE 4 FOR RECOMMENDATIONS ABOUT YOUR CURRENT MEDICAL CONDITION(S) AND SIGN THE PARTICIPANT DECLARATION.

2022 PAR-Q+

The Physical Activity Readiness Questionnaire for Everyone

If you answered NO to all of the FOLLOW-UP questions (Pgs 2-3) about your medical condition, you are ready to become more physically active- sign the PARTICIPANT DECLARATION below:

- It is advised that you consult a qualified exercise professional to help you develop a safe and effective physical activity plan to meet your health needs.
- You are encouraged to start slowly and build up gradually- 20 to 60 minutes of low to moderate intensity exercise, 3-5 days per week including aerobic and muscle strengthening exercises.
- As you progress, you should aim to accumulate 150 minutes or more of moderate intensity physical activity per week.
- If you are over the age of 45 years and NOT accustomed to regular vigorous to maximal effort exercise, consult a qualified exercise professional before engaging in this intensity of exercise.

If you answered YES to one or more of the follow-up questions about your medical condition:

You should seek further information before becoming more physically active or engaging in a fitness appraisal. You should complete the specially designed online screening and exercise recommendations program- the ePARmed-X+ at www.eparmedx.com and/or visit a qualified exercise professional to work through the ePARmed-X+ and for further information.

Delay becoming more active if:

- You have a temporary illness such as a cold or fever; it is best to wait until you feel better.
- You are pregnant- talk to your health care practitioner, your physician, a qualified exercise professional, and/or complete the ePARmed-X+ at www.eparmedx.com before becoming more physically active.
- Your health changes- talk to your doctor or qualified exercise professional before continuing with any physical activity programs.
- You are encouraged to photocopy the PAR-Q+. You must use the entire questionnaire and NO changes are permitted.
- The authors, the PAR-Q+ Collaboration, partner organizations, and their agents assume no liability for persons who undertake physical activity and/or make use of the PAR-Q+ or ePARmed-X+. If in doubt after completing the questionnaire, consult your doctor prior to your physical activity.

PARTICIPANT DECLARATION

- All persons who have completed the PAR-Q+ please read and sign the declaration below.
- If you are less then the legal age required for consent or require the assent of a care provider, your parent, guardian, or care provider, they must also sign this form.

I, the undersigned, have read, understood to my full satisfaction and completed this questionnaire. I acknowledge that this physical activity clearance is valid for a maximum of 12 months from the date it is completed and becomes invalid if my condition changes. I also acknowledge that the community/fitness center may retain a copy of this form for records. In these instances, it will maintain the confidentiality of the same, complying with applicable law.

Name _____ Date _____

Signature _____ Date _____

Witness _____ Date _____

Signature of Parent/Guardian/Care Provider: _____ Date _____

For more information, please contact www.eparmedx.com

2022 PAR-Q+

The Physical Activity Readiness Questionnaire for Everyone

Medical Clearance for Exercise Participation:

TO

Name: _____

Clinic: _____

Address: _____

Phone: _____

Fax: _____

Date: _____

Year: _____

FROM

Name: _____

Title: _____

Facility: _____

Address: _____

Phone: _____

Fax: _____

Email: _____

Dear,_____ (health care provider's name)

Your patient, _____ (DOB) _____, has applied for enrollment in the health/fitness testing and/or exercise programs at the Woodson YMCA. The health/fitness testing involves a submaximal test for cardiorespiratory fitness, body composition analysis, flexibility tests, and a muscular strength and endurance tests. The exercise programs are designed to start easy and become progressively more difficult over a period of time. A more detailed description of the fitness testing protocols and exercise programs is available upon request. All health/fitness assessments and exercise programs will be guided by a qualified fitness professional holding a nationally-accredited personal training certification as well as certifications in cardiopulmonary resuscitation (CPR) and the use of an automated external defibrillator (AED).

By completing the box below, however, you are not assuming any responsibility for our administration of the health/fitness testing and/or exercise programs. If you know of any medical or other reasons why participation in the fitness testing and/or exercise programs by this applicant would be unwise, please indicate so on this form.

If you have any questions, please feel free to call me at _____.

Report of Health Care Provider

❑ I know of no reason why the applicant may not participate in the fitness testing and/or exercise program.

❑ I believe that the applicant may participate, but I recommend the following guidelines and precautions are observed:

_____

_____

❑ The applicant should not engage in the following activities

_____

_____

❑ I recommend that the applicant NOT participate at this time

Signature _____ Date _____

I hereby consent to the release of pertinent health information to The Woodson YMCA for the purpose of designing a safe and effective exercise program. I understand that this information will be kept confidential and only persons involved in the design and implementation of my exercise program will be viewing the information.