Illinois Valley YMCA

Personal Training

HEALTH SCREENING FORM

Name: _____ Date: _____

Male: ___ Female: ___ Age: _____ Height: _____ Weight: _____

This form is intended to obtain relevant information about your health that will assist the staff in helping you with your program. Please answer all questions to the best of your knowledge.

1. Weight

   How would you describe your current body weight?

   _____ Underweight (under ideal) _____ 5 to 19 lb overweight

   _____ Normal _____ More than 20 lb overweight

2. Blood pressure

   Do you have high blood pressure? Yes No

   Have you had high blood pressure in the past? Yes No

   Are you on medication for high blood pressure? Yes No

3. Smoking

   Do you smoke? Yes No

   Are you a former smoker? Yes No

   If yes, please give the date you quit. _____

4. Diabetes

   Do you have diabetes? Yes No

5. Heart problems

   Have you ever had a heart attack? Yes No

   Have you ever had heart surgery? Yes No

   Have you ever had angina? Yes No

6. Family history

   Have any of your blood relatives had heart disease, heart surgery, or angina? Yes No

7. Orthopedic problems

   Do you have any serious orthopedic problems that would prevent you from exercising? Yes No

   If yes, please explain.

   _____

   _____

   _____

8. Other problems

   Do you have any reason to believe you should not exercise? Yes No

   If yes, please explain.

   _____

   _____

   _____

9. Emergency

   Please list a relative we may contact in case of an emergency:

   Name: _____ Telephone: _____

   Relation: _____

From *Exercise Testing and Prescription Lab Manual* by Edmund Acevedo and Michael Starks, 2003, Champaign, IL: Human Kinetics.

MEDICAL HISTORY FORM

Name: _____ Date: _____

Address: _____ Age: ____ Date of birth: _____

_____ Sex: ____ Height: _____ Weight: _____

Home phone: (__) _____ Business phone: (__) _____

In case of emergency contact _____

Contact's phone: (__) _____

Name of personal physician: _____

Date/Reason last consulted: _____

Physician's phone: (__) _____

1. Please place a check mark beside those conditions that you currently have or have had in the past.

_____ heart attack	_____ thrombophlebitis	_____ 5 to 19 lbs overweight
_____ angina	_____ asthma	_____ high blood pressure
_____ abnormal ECG	_____ fixed-rate pacemaker	_____ low blood pressure
_____ heart medications	_____ embolism	_____ diabetes
_____ valve disease	_____ respiratory infections	_____ epilepsy
_____ aneurysm	_____ irregular heartbeats	_____ anemia

2. Has your physician ever advised you against exercise? ____Yes ____ No
   If yes, why? _____
   _____
   _____

3. Do you have or have you had any of the following conditions?

_____ arthritis	_____ ankle/foot injury	_____ shoulder/clavicle injury
_____ low back pain	_____ arm/elbow injury	_____ knee/thigh injury
_____ calcium deposits	_____ nerve damage	_____ upper back injury
_____ head/neck injury	_____ bone fracture	_____ wrist/hand injury
_____ hip/pelvis injury	_____ tennis elbow	

   If yes, why? _____
   _____
   _____

4. Are you currently receiving physical therapy? ____Yes ____ No
   If yes, please furnish your therapist's name and phone number: _____
   _____ (__) _____

5. May we call him/her? ____Yes ____ No

6. Do you have any conditions or past injuries that may limit the range of motion of your muscles, joints, bones, spinal column, or any other part of your body that may be aggravated by exercise? ____Yes ____ No
   If yes, please explain: _____
   _____
   _____

(continued)

MEDICAL HISTORY FORM (cont.)

7. Are you currently taking any medications on a regular basis? _____Yes _____ No
   If yes, please list names and dosages of each: _____
   _____
   _____
8. Are you currently under a doctor's care? _____Yes _____ No
   If yes, please furnish his/her name and phone number: _____
   _____ ( ) _____
9. May we call him/her? _____Yes _____ No
10. What is your current weight? _____
11. What was your weight 1 year ago? _____ 5 years ago: _____ at age 20? _____
12. Are you currently on a specific diet? _____Yes _____ No
    If yes, please describe: _____
    _____
    _____
13. Are you tired or fatigued most of the day? _____Yes _____ No
14. Are you tired or fatigued at a specific time of the day? _____Yes _____ No
    If yes, when: _____
    _____
    _____
15. On the average, how many times per year do you travel extensively? _____
16. On the average, how many hours a day do you spend at work? _____
    How many days a week? _____
17. How would you rate the level of physical activity you perform while at work?
    _____ very inactive _____ inactive _____ moderate _____active _____very active
18. How would you rate the level of physical activity you perform during leisure time?
    _____ very inactive _____ inactive _____ moderate _____active _____very active
19. Are you presently performing any standard physical fitness program (e.g., aerobics)?
    _____Yes _____ No
    Explain: _____
    _____
    _____
20. How physically fit do you feel at present?
    _____ unfit _____ less than fit _____ fit _____more than fit _____very fit
21. Providing the equipment and facilities were available, which physical activities would you be interested in learning about and participating in?

_____ hiking	_____ bicycling	_____ aerobics
_____ weightlifting	_____ swimming	_____ jogging
_____ handball	_____ calisthenics	_____ volleyball
_____ tennis	_____ badminton	_____ racquetball/squash
_____ golf	_____ yoga	_____ supervised conditioning program
_____ sailing	_____ horseback riding	

(continued)

MEDICAL HISTORY FORM (cont.)

22. Do you have any exercise equipment or device at home? ____Yes ____ No
    If yes, specify: _____

23. Did you participate in high school or college athletics? ____Yes ____ No
    If yes, please specify: _____

24. Do you think that there are any activities that would not interest you or might cause you discomfort or pain? ____Yes ____ No
    If yes, please specify: _____

25. What are your primary reasons for visiting _____:
    name of your facility

____ general conditioning	____ swimming	____ stress reduction
____ muscular strength	____ running	____ socializing
____ flexibility	____ weight loss	____ facility offerings
____ cardiovascular conditioning		

I have answered the preceding questions to the best of my ability. I have understood all the questions asked of me and have been given the opportunity to have any questions clarified to my satisfaction. I further understand that thorough and honest responses to these questions are essential to my safety, health, and wellness.

Signature _____ Date _____

Witness _____ Date _____

From *Exercise Testing and Prescription Lab Manual* by Edmund Acevedo and Michael Starks, 2003, Champaign, IL: Human Kinetics.

RISK STRATIFICATION FORM

Name: _____ Date: _____

Risk factors	Yes/No	Comments
Positive (Yes +1)		
Family history	_____	_____
Cigarette smoking	_____	_____
Hypertension	_____	_____
Hypercholesterolemia	_____	_____
Impaired fasting glucose	_____	_____
Obesity	_____	_____
Sedentary lifestyle	_____	_____
Negative (Yes -1)	_____	_____
High serum HDL cholesterol	_____	_____
Total risk factors _____		

Major signs or symptoms suggestive of CVD or PVD	Yes/No	Comments
(Yes +1)		
Pain, discomfort in the chest (or other anginal equivalent), neck, jaw, arms, or other areas that may be due to ischemia	_____	_____
Shortness of breath at rest or with mild exertion	_____	_____
Dizziness or syncope	_____	_____
Orthopnea or paroxysmal nocturnal dyspnea	_____	_____
Palpitations or tachycardia	_____	_____
Intermittent claudication	_____	_____
Known heart murmur	_____	_____
Unusual fatigue or shortness of breath with usual activities	_____	_____
Total signs or symptoms _____		

(continued)

RISK STRATIFICATION FORM (cont.)

Initial risk stratification

	Low risk ____	Moderate risk ____	High risk ____
Current medical examination			
Moderate exercise	**Not necessary**	**Not necessary**	**Recommended**
Vigorous exercise	**Not necessary**	**Recommended**	**Recommended**
Physician supervision of exercise test			
Submaximal test	**Not necessary**	**Not necessary**	**Recommended**
Maximal test	**Not necessary**	**Recommended**	**Recommended**

Additional Medical Concerns

Medications: _____

Orthopedic limitations: _____

Other: _____

Note: For all **positive risk factors** that are answered **yes,** add 1 in the space provided; and for all **negative risk factors** answered **yes,** subtract 1 in the space provided. For all **signs or symptoms** answered **yes,** add 1 to the space provided. Scores should be totaled and the individual stratified according to ACSM guidelines.

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EXERCISE PRESCRIPTION INTERVIEW FORM

Before this interview, be sure that the client is informed of the benefits and importance of fitness, his or her specific health-related fitness assessment results, and the exercise prescription guidelines. The fitness-assessment results and the exercise prescription guidelines are found on the Fitness Assessment Form With Exercise Prescription Guidelines (page 124). It is also important that the client be aware of the connection between choice of health-related behaviors and health fitness-related outcomes (e.g., improved overall health, enhanced fitness, decrease in morbidity and mortality).

Preferences and Interests Related to Fitness

What mode (type) of physical activity do you enjoy (e.g., walking, bicycling, jogging, swimming, doing yardwork, etc.)?

Do you prefer group or individual training? What type of training environment do you prefer (e.g., outdoor, indoor, cold, hot, pool, etc.)

Are there activities that you do not like and would like to avoid?

Would you like to do the same activities regularly, or would you prefer variety in your workout schedule?

Would you like more information or resources on particular activities or health-related information?

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Illinois Valley YMCA
Facility User/Visitor Agreement

Date_____

Name_____ Address_____

City_____ State_____ Zip Code_____ Age_____ Sex_____

Home Phone_____ WorkPhone_____ Email_____

In Case of an Emergency, Please Notify:
Name_____ Phone Number_____
Relation_____

I agree to follow all rules and regulations of the Illinois Valley YMCA while in, upon or about the premises or while using or observing the premises or any facilities or equipment, or participating in any program affiliated with the IVYMCA without respect as to location, and understand and agree that I may be expelled at any time, with no refund of any monies paid, for failure to abide by such rules and regulations.

In consideration of being permitted to utilize the facilities, services and programs of the YMCA for any purpose, including but not limited to observation or use of facilities or equipment or participation in any program affiliated with the YMCA without respect as to location, I hereby agree to the following:

1. I understand that activities at the facility or elsewhere, including use of equipment and participation in programs, can involve movement, strain and other elements that create risk of serious injury or death. I hereby assume full responsibility for and risk of bodily injury, death or property damage or loss, regardless of the severity, that I or my minor child/ward may sustain from my or my minor child/ward's presence in, upon or about the premises or while using or observing the premises or any facilities or equipment, or participating in any program affiliated with the IVYMCA without respect as to location, except for any injury, damage or loss that is caused solely by the IVYMCA's gross negligence.
2. I, for myself, any personal representatives, assigns, heirs and next of kin, hereby fully release, waive, discharge and covenant not to sue the Illinois Valley YMCA, its operating centers, their respective officers, directors, Board of Managers, Trustees, members, volunteers, employees, or agents(the "Releases") and each of them from any and all claims for injuries, damages or loss that I or my minor child/ward may have or which may accrue to me or my minor child/ward from my and/or my minor child/ward's presence in, upon or about the premises or while using or observing the premises or any facilities or equipment, or participating in any program with the IVYMCA without respect as to location except for any injury, damage or loss that is caused solely by IVYMCA's gross negligence.
3. I hereby agree to indemnify and save and hold harmless the releases and each of them from any loss, liability, damage or cost they may incur from my or my minor child/ward's presence in, upon or about the premises or while using or observing the premises or any facilities or equipment, or participating in any program affiliated with the IVYMCA without respect as to location, except for any loss, liability, damage or cost that is caused solely by the IVYMCA's gross negligence.

I further expressly agree that the foregoing assumption of risk, release, waiver and indemnity agreement is intended to be as broad and inclusive as is permitted by the law of the State of Illinois and if any portion thereof is held invalid, it is agreed that the balance shall, notwithstanding, continue in full legal force and effect.

This agreement applies to all past, present and future visits and uses by me to any YMCA facility or property.

I have read and voluntarily signed this assumption of risk, release, waiver and indemnity agreement, and further agree that no oral representations, statements or inducements apart from the foregoing written agreement have been made.

DO NOT SIGN UNTIL YOU HAVE READ THE ABOVE AGREEMENT. THIS AGREEMENT CONTAINS A WAIVER AND RELEASE.

Signature_____ Date_____
(Participant's signature)

Signature_____ Date_____
(in case of a minor ONLY: Parent/Guardian's Signature)

ILLINOIS VALLEY Y
12-HOUR CANCELLATION POLICY

ILLINOIS VALLEY Y * 300 WALNUT DRIVE PERU, IL 61354 * 815-223-7904

Please read the policy information, then print and sign your name. By signing this you are agreeing to the terms and conditions of the policy.

I, _____ (Client) agree to notify the trainer or the front desk at the Illinois Valley Y (815-223-7904) 12 hours prior to scheduled session, if I need to cancel. I understand that if I fail to cancel I will still be charged for the session.

I, _____ (Trainer) agree to notify client 12 hours prior to scheduled session, if I need to cancel. I understand that if I fail to cancel or schedule a replacement, I will provide client with one free session.

Client Signature _____ Date _____

(Print Name) _____

Trainer Signature _____ Date _____

(Print Name) _____

NO CALL/NO SHOW = AUTOMATIC CHARGE. EXCLUSIONS AND LIMITATIONS MAY APPLY