

PERSONAL TRAINING

THIS PACKAGE WILL GIVE YOUR TRAINER THE INFORMATION THEY WILL NEED TO DESIGN YOUR
PROGRAM. PLEASE PROVIDE AS MUCH INFORMATION AS POSSIBLE.
RETURN COMPLETED FORMS TO TIMMS COMMUNITY CENTRE AND REGISTER FOR THE PACKAGE
THAT BEST SUITS YOUR NEEDS. THIS PACKAGE WILL BE FORWARDED TO YOUR PERSONAL TRAINER
WHO WILL CONTACT YOU TO ARRANGE FOR YOUR TRAINING SESSIONS.

**PLEASE NOTE: COMPLETED PERSONAL TRAINING PACKAGE MUST BE SUBMITTED ALONG WITH
PAYMENT FOR TRAINING SESSIONS.**



PAR-Q AND MEDICAL HISTORY

FIRST NAME _____ LAST NAME _____
 EMAIL _____ AGE _____
 PHONE _____

PACKAGE SELECTED:

INDIVIDUAL SESSIONS: ___ 3X ONE HOUR ___ 5X ONE HOUR ___ 10X ONE HOUR
 TANDEM SESSIONS (WITH ANOTHER PERSON): ___ 3X ONE HOUR ___ 5X ONE HOUR ___ 10X ONE HOUR

EMERGENCY CONTACT INFO

EMERGENCY CONTACT NAME _____
 RELATIONSHIP _____ PHONE _____

PHYSICAL ACTIVITY READINESS

PLEASE ANSWER "YES" OR "NO" TO THE FOLLOWING QUESTIONS:

- | | |
|-------|---|
| Y / N | Has your doctor ever said that you have a heart condition that requires approval or supervision for physical activity? |
| Y / N | Do you feel chest pains when you perform physical activity? |
| Y / N | Do you experience loss of balance due to dizziness or do you ever lose consciousness? |
| Y / N | Do you have a bone or joint problem that could be worsened by a change in your physical activity? |
| Y / N | Do you take medications, either prescription or non-prescription, that may affect your ability to participate in physical activity? |
| Y / N | Are you pregnant or have you had a recent child birth? |
| Y / N | Have you had a recent surgery? |
| Y / N | Do you know of any other reason why you should not engage in physical activity? |

IF YOU HAVE MARKED "YES" TO ANY OF THE ABOVE, PLEASE ELABORATE: _____

PAR-Q AND MEDICAL HISTORY (CONTINUED)

MEDICAL HISTORY

PLEASE SELECT ALL THAT APPLY (EITHER CURRENTLY OR IN THE PAST):

- | | |
|---|--|
| <input type="checkbox"/> Heart condition | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Chest pains | <input type="checkbox"/> Injury |
| <input type="checkbox"/> Faint or dizzy spells | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Bone or joint problems | <input type="checkbox"/> High cholesterol |
| <input type="checkbox"/> Back problems | <input type="checkbox"/> Eating disorder |
| <input type="checkbox"/> Other: _____ | <input type="checkbox"/> Asthma |

LIST ANY KNOWN ALLERGIES OR SENSITIVITIES: _____

ANY INJURIES YOUR TRAINER SHOULD BE AWARE OF: _____

ANY OTHER INFORMATION YOU THINK YOUR TRAINER SHOULD KNOW: _____

I, _____ agree that the information on this form is true and accurate to the best of my knowledge and that I have disclosed any conditions or history that may put me at risk. I understand that my personal trainer is not able to provide me with medical advice with regard to any medical conditions I may have and that this information is used only as a guideline to the limitations of my ability to exercise. I will release my personal trainer from any liability for injuries or worsened health conditions that result from training. I take full responsibility for consulting my physician before engaging in physical activity if I answered "YES" to one or more of the previous questions.

SIGNATURE: _____ DATE SIGNED: _____



NEW CLIENT QUESTIONNAIRE

CLIENT NAME: _____ DATE: _____

REQUESTED TRAINER: _____

AVAILABILITY

Please circle the times you are (generally) available to train:

Notes (specific times):

Morning (6am-11am)	Mo	Tu	We	Th	Fr	Sa	Su	_____
Mid-day (11am-4pm)	Mo	Tu	We	Th	Fr	Sa	Su	_____
Evenings (4-9pm)	Mo	Tu	We	Th	Fr	Sa	Su	_____

Please list any specific times/dates you are not available:

LIFESTYLE

Do you smoke? ____Yes ____No If Yes how many per day? _____

Do you drink alcohol?

____Never ____Occasionally ____Moderately (3 or less per day) ____Heavily (4+ per day)

How many hours do you sleep at night? _____

What would you rate your stress level from 1 to 10 (1= very low, 10= very high)? _____

OCCUPATIONAL

What is your current occupation? _____

Which most accurately describes your job? ____Sedentary ____Active ____Physically demanding

Does your job require extended periods of sitting? ____Yes ____No

Does your job require extended periods of standing? ____Yes ____No

Does your job require walking, running, climbing, or crawling? ____Yes ____No

Does your job require repetitive movements? ____Yes ____No

NEW CLIENT QUESTIONNAIRE (CONTINUED)

FITNESS GOAL SETTING

What would you rate your fitness level from 1 to 10 (1= very low, 10= very high)? _____

How often do you exercise? _____

What type of exercise have you been doing over the past 6 months?

____ Walking/Running ____ Weight Training ____ Group Fitness ____ Sports ____ Swimming

Other: _____

If your participation is lower than what you would like it to be, what are the reasons?

____ Lack of interest ____ Illness/Injury ____ Plateau ____ Lack of results ____ Money

____ Feeling self-conscious ____ Other: _____

What results do you wish to achieve?

____ Reduce body fat

____ Stress management

____ Increase muscle size

____ Tone

____ Improve flexibility

____ Rehabilitate an injury

____ Other: _____

____ Sports conditioning

____ Strength training

____ Increase stamina

____ Weight loss

____ A certain look

____ Consistency/motivation

____ Recomposition

Any Specific Areas of Focus?

____ Stomach

____ Legs

____ Glutes

____ Arms

____ Other: _____

____ Back

____ Shoulders

____ Hips

____ Waist

____ Chest

ANY OTHER INFORMATION YOU THINK YOUR TRAINER SHOULD KNOW: _____



CONSENT AND RELEASE AGREEMENT

CLIENT NAME: _____ DATE: _____

This contract will provide the necessary information to make an informed decision of whether or not to participate in a personal training program. Please do not hesitate to ask any questions.

REVIEW THE FOLLOWING STATEMENTS AND INITIAL TO VERIFY YOUR UNDERSTANDING

_____ I understand there are inherent risks in participating in a program of strenuous exercise. I accept full responsibility for consulting a physician about any health conditions of mine that may affect my ability to participate in the fitness program. If I choose not to see a physician for medical clearance prior to beginning a fitness program, I verify that I am doing so at my own risk and against recommendation of my personal trainer.

_____ I release my personal trainer and all Langley City Staff of any liability for any injuries or worsened health conditions resulting from my participation in the fitness program.

_____ I certify that the answers to the questions outlined on all of my submitted personal training forms are true and complete to the best of my knowledge.

_____ I understand that I am not obligated to perform any activity that I do not wish to do, and that it is my right to refuse participation at any time during my training sessions.

_____ I understand that if I feel lightheaded, faint, dizzy, nauseated, pain, or discomfort, I am to inform my personal trainer and stop the exercise immediately.

_____ I understand the results of any fitness program cannot be guaranteed and that my progress depends on my effort and cooperation in and outside of the sessions.

_____ I understand if I arrive late to a scheduled training session that I will not receive the full time allotted. If my personal trainer is late for a session, I will still receive the full session time.

_____ I understand that all personal training sessions are non-transferable and non-refundable.

_____ I understand that my personal trainer operates on a scheduled appointment basis. I agree that if I do give notice of cancellation within 24 hours I will be charged in full for that session.

I, _____ certify that I have read and initialed the statements above to verify my understanding and consent. I fully accept the responsibility to participate in a personal training program.

CLIENT SIGNATURE

DATE SIGNED