Personal Training Registration Form

What about Personal Training?
Your YMCA's team of personal trainers is group of certified and experienced professionals dedicated to helping you achieve your health and fitness goals. Your time and Health are valuable, so make sure you get the most out of your membership and each workout. Whether you are an adult, teen or youth consulting with a personal trainer will enable you to get started with a professionally designed and individualized exercise program.

Name: _____

A.M. Phone: _____ P.M. Phone: _____

Trainer Requested: _____ Package: _____ Desired Sessions/Week: _____

Weekly Availability:
Mondays: From _____To _____
Tuesdays: From _____To _____
Wednesdays: From _____To _____
Thursdays: From _____To _____
Fridays: From _____To _____
Saturdays: From _____To _____
Sundays: From _____To _____

Informed Consent and Release: I do acknowledge the risk of injury that is possible during sports and fitness programs and I assume all risks and hazards to such participation including transportation to and from activities. I waive, release, absolve, indemnify and agree to hold harmless the YMCA, organizers, supervisors, officers, directors, coaches, participants and referees. I do acknowledge the risk of injury is possible.

Late Policy: Participants are responsible for arriving on time to their sessions. YMCA staff is obligated to wait 15 minutes after the session start time. After 15 minutes, the session will be forfeited and is non-refundable.

Cancellation Policy: Participants are asked to call 24 hours in advance of the scheduled session to cancel. Failure to cancel will result in session forfeited and is non-refundable.

Individual and partner training packages are good for 12 months from date of purchase. Your Trainer will set up your sessions with you to best suit your schedule.

Signature: _____ Date: _____

STAFF USE ONLY

Paid _____ Date _____ Staff Initials_____

Trainer Confirmed _____ First Appointment _____

Union County Family YMCA

PAR – Q & YOU

(A Questionnaire for People Age 15 to 69)

Regular physical activity is fun and healthy, and increasingly more people are starting to become more active every day. Being more active is very safe for most people. However, some people should check with their doctor before they start 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:

YES	NO	
____	____	1. Has your doctor ever said that you have a heart condition and that you should only do physical activity recommended by a doctor?
____	____	2. Do you feel pain in your chest when you do physical activity?
____	____	3. In the past month, have you had chest pain when you were not doing physical activity?
____	____	4. Do you lose your balance because of dizziness or do you ever lose consciousness?
____	____	5. Do you have a bone or joint problem that could be made worse by a change in your physical activity?
____	____	6. Is your doctor currently prescribing drugs (for example, water pills) for your blood pressure or heart condition?
____	____	7. Do you know of <u>any other reason</u> 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 activity to those which are safe for you. Talk with your doctor about the kinds of activities you wish to participate in and follow his/her advice.
- Find out which community programs are safe and helpful for you.

If NO to all questions

If you answered NO honestly to all PAR-Q questions you can be reasonably sure that you can:

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

Delay becoming much more active:

- If you are not feeling well because of a temporary illness such as a cold or fever – wait until you feel better, or
- 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.

Informed Use of the PAR-Q: The Canadian Society for Exercise Physiology, Health Canada, and their agents assume no liability for persons who undertake physical activity and if in doubt after completing this questionnaire, consult you doctor prior to physical activity.

"I have read, understand and completed this questionnaire. Any question I had were answered to my full satisfaction."

Name _____

Signature _____ Date _____

Signature of Parent_____ Witness_____

Or Guardian (for participants under the age of majority)

Note: This physical activity clearance is valid for a maximum of 12 months from the date it is completed and becomes invalid if your condition changes so that you would answer YES to any of the seven questions.

HEALTH/MEDICAL HISTORY QUESTIONNAIRE

PERSONAL INFORMATION:

NAME:_____ DATE:_____/_____/_____

ADDRESS:_____

CITY:_____ STATE:_____ ZIP:_____

HOME PHONE:_____-_____-_____ WORK PHONE_____-_____-_____

DATE OF BIRTH:_____/_____/_____ AGE:_____ GENDER: M____ F____

HEIGHT:_____ WEIGHT:_____

OCCUPATION:_____

IF MINOR, PARENT'S NAMES:_____

PHYSICIAN:_____PHYSICIAN PHONE NUMBER:____-_____-_____

PHYSICIAN'S ADDRESS:_____CITY:_____

LIST ANY CHRONIC ILLNESS FOR WHICH YOU SOUGHT MEDICAL CARE:

_____DATE:_____/_____/_____

_____DATE:_____/_____/_____

_____DATE:_____/_____/_____

HOSPITALIZATIONS:

YEAR REASON

_____ _____

_____ _____

ALLERGIES TO MEDICATIONS: _____

LIST CURRENT MEDICATIONS: _____

DO YOU SMOKE? YES NO IF YES HOW MUCH PER DAY? _____

HOW MANY YEARS? _____

FAMILY HISTORY

LIST ANY IMMEDIATE FAMILY MEMBER(S) WHO HAVE BEEN DIAGNOSED WITH OR WHO HAVE DIED FROM ANY OF THE FOLLOWING CONDITIONS:

CONGESTIVE HEART FAILURE: _____

DIABETES: _____

HEART ATTACK: _____

HIGH BLOOD PRESSURE: _____

STROKE: _____

HAVE YOU EVER HAD OR BEEN TOLD THAT YOU HAVE: (CIRCLE YES OR NO. IF THE ANSWER IS YES, PLEASE INDICATE IF THE CONDITION IS CURRENT OR WAS IN THE PAST. IF IN THE PAST, PLEASE INDICATE THE DATE IT OCCURRED.)

CONDITION	STATUS				DATE
ANEMIA	NO	YES	CURRENT	PAST	_____/_____/_____
ANGINA	NO	YES	CURRENT	PAST	_____/_____/_____
ARTHRITIS (OSTEO)	NO	YES	CURRENT	PAST	_____/_____/_____
ARTHRITIS(RHEUMATIOD)	NO	YES	CURRENT	PAST	_____/_____/_____
ASTHMA	NO	YES	CURRENT	PAST	_____/_____/_____
ASTHMA(EXERCISE IND.)	NO	YES	CURRENT	PAST	_____/_____/_____
BRONCHITIS	NO	YES	CURRENT	PAST	_____/_____/_____
BURSITIS	NO	YES	CURRENT	PAST	_____/_____/_____
CHRONIC FATIGUE SYNDROME	NO	YES	CURRENT	PAST	_____/_____/_____
CORONARY ARTERY DISEASE	NO	YES	CURRENT	PAST	_____/_____/_____
DEPRESSION	NO	YES	CURRENT	PAST	_____/_____/_____
DIABETES	NO	YES	CURRENT	PAST	_____/_____/_____
EMOTIONAL DISORDERS	NO	YES	CURRENT	PAST	_____/_____/_____
EMPHYSEMA	NO	YES	CURRENT	PAST	_____/_____/_____
ENLARGED HEART	NO	YES	CURRENT	PAST	_____/_____/_____
EPILEPSY	NO	YES	CURRENT	PAST	_____/_____/_____
HEART ATTACK	NO	YES	CURRENT	PAST	_____/_____/_____
HEART MURMUR	NO	YES	CURRENT	PAST	_____/_____/_____
HERNIA	NO	YES	CURRENT	PAST	_____/_____/_____
HEPATITIS	NO	YES	CURRENT	PAST	_____/_____/_____
HIGH BLOOD PRESSURE	NO	YES	CURRENT	PAST	_____/_____/_____
HIGH BLOOD CHOLESTEROL	NO	YES	CURRENT	PAST	_____/_____/_____
IRREGULAR HEART BEAT	NO	YES	CURRENT	PAST	_____/_____/_____
KIDNEY DISEASE	NO	YES	CURRENT	PAST	_____/_____/_____

LOW BLOOD PRESSURE	NO	YES	CURRENT	PAST _____/_____/_____
PERIPHERAL VASCULAR D.	NO	YES	CURRENT	PAST _____/_____/_____
PHEUMONIA	NO	YES	CURRENT	PAST _____/_____/_____
PHEUMATIC FEVER	NO	YES	CURRENT	PAST _____/_____/_____
THYROID DISEASE	NO	YES	CURRENT	PAST _____/_____/_____
TUBERCULOSIS	NO	YES	CURRENT	PAST _____/_____/_____
ULCER DISEASE	NO	YES	CURRENT	PAST _____/_____/_____
YELLOW JAUNDICE	NO	YES	CURRENT	PAST _____/_____/_____

ANY OTHER CONDITION NOT LISTED: _____

HAVE YOU PREVIOUSLY HAD A TREADMILL STRESS TEST? YES NO

IF YES, WHERE: _____

WHEN: _____

RESULT: _____

HAVE YOU EVER EXPERIENCED ANY OF THE FOLOWING?

CHEST PAIN OR HEAVINESS WITH EXERCISE	YES	NO
CHEST PAIN OR HEAVINESS WITH DAILY ACTIVITY OR AT REST	YES	NO
IRREGULAR HEART BEAT, PALPITATIONS, HEART SKIPPING BEATS	YES	NO
DIZZYSPELLS OR LIGHT-HEADEDNESS	YES	NO
WAKING UP IN THE MIDDLE OF THE NIGHT TO CATCH YOUR BREATH	YES	NO
UNEXPLAINED SHORTNESS OF BREATH	YES	NO
SHORTNEDD OF BREATH WHEN LYING FLAT	YES	NO
SLEEPING ON MORE THAN ONE PILLOW TO PREVENT	YES	NO
SHORTNESS OF BREATH	YES	NO
PAINFUL OR SWOLLEN JOINTS	YES	NO
BLOOD IN URINE	YES	NO

ANY OTHER MEDICAL PROBLEMS NOT ALREADY INDICATED: _____

EXERCISE PROFILE

DO YOU HAVE ANY TYPE OF BIOMECHANICAL JOINT PROBLEMS?

YES___ NO____ IF YES, EXPLAIN: _____

DO YOU CURRENTLY HAVE ANY EXERCISE-INDUCED INJURIES?

YES___ NO____ IF YES, EXPALIN: _____

HAVE YOU HAD A PREVIOUS EXERCISE-INDUCED INJURY?

YES____ NO____ IF YES, EXPLAIN: _____

WERE MEDICAL CARE AND/OR PHYSICAL THERAPY INVOLVED?

YES___ NO____ IF YES, EXPLAIN: _____

ARE YOU CURRENTLY INVOLVED IN ANY TYPE OF EXERCISE ROUTINE?

YES____ NO____ IF YES, EXPLAIN: _____