Personal Training New Client Form

Name_____Date_____DOB_____

Home Phone #_____Cell Phone #_____

# of Sessions Purchased_____ Desired Start Date_____

Available days: M T W Th F Sa Su

Available times: Early morning mid-morning afternoon evenings

Special Request_____

_____

OFFICE STAFF:

Amount Paid:_____ Date:_____ Receipt #_____

Folder: YES NO Staff:_____

Fitness Programmer:
Trainer assigned: _____ Date:_____

Personal Trainer:
1st Appointment: Date_____ Time_____ Initials_____

CONSULTATION FORM
Personal Training

Name_____

Workout Experience (1 2 3 4 5) light to heavy

What type of training?_____

How long ago? _____How long did you stay with it?_____

Did you enjoy it? _____

Resistance Training Experience

What type of training? (free/machine/circuit)_____

What machine or exercises? _____

Frequency? _____

Did you enjoy it?_____

Cardiovascular Training Experience

What type of training? (running, swimming, classes, biking, etc.)_____

What equipment? _____

Frequency? _____

Did you enjoy it?_____

Do you have any physical limitations?_____

What are your fitness or lifestyle goals?

Short Term (1-6 months) _____ _____ _____

Long Term (6 months-3 years)_____ _____

H/Fitness/Personal Training/Consultation Forms/Consultation form 0919

Personal Training-Health Questionnaire

DERBY RECREATION COMMISSION

Name_____

Gender_____ Age_____

Address_____City_____

Phone home_____cell_____work_____

Emergency Contact_____phone_____

Weight:_____ Height:_____

For most people, physical activity should not pose any problem or hazard, the following questions are designed to identify the small number of adults for whom physical activity might be inappropriate or those who should have medical advice concerning the type of activity most suitable for them.

Common sense is your best guide in answering these questions. Please read them carefully and check the questions that applies to you,.

Has your doctor ever said you have heart trouble? If so, please describe the problem and when it was diagnosed.

_____

□ Do you frequently have pains in your heart and chest?

□ Do you often feel faint or have spells of severe dizziness?

□ Has a doctor ever told you that your blood pressure is too high?

□ Has your doctor ever told you that you have a bone or joint problem, such as arthritis that has been aggravated by exercise or might be made worse by exercise?

□ Is there a good physical reason not mentioned here why you should not follow an activity program even if you wanted to do so?

□ Are you over age 65 and/or not accustomed to vigorous exercise?

□ Are you or have you ever been a diabetic?

□ Are you now or have you been pregnant within the last three months?

Resting Heart Rate_____

Karvonen Zone

MHR=Max Heart Rate (220-age)
RHR=Resting Heart Rate (bpm)
HRR=Heart Rage Reserve (MHR-RHR)
THR=Target Heart Rate Zone
LL=Lower Limit
UL=Upper Limit

Karvonen Formula for Target Heart Rate Zone

Aerobic Fat Burning Efficiency

HRR_____x .55=_____+RHR=LL HRR_____X.70=_____+RHR=UL

Cardio Respiratory Fitness

HRR_____x .70=_____+RHR=LL HRR_____X.85=_____+RHR=UL

☐ Have you had any surgery in the last three months?

Have you been hospitalized in the last two years? If so, when and why?

_____

Have you ever seen a chiropractor, acupuncturist, or other alternative medicine practitioner? If so, when and why?

_____

Please list all medications you are taking at the present time.

_____

_____

Please check the box if you have ever experienced any of the following symptoms.

☐ Pain or discomfort in the chest

☐ Unaccustomed shortness of breath

☐ Dizziness

☐ Labored or uncomfortable breathing, with or without pain

☐ Swollen knees

☐ Heart Palpitations

☐ Heart Murmur

☐ Limping

Do you have high blood pressure? If so, what is your current blood pressure without medication?

_____

Are you taking any medication for hypertension? If so, what medication?

_____

☐ Is your total serum cholesterol level over 240?

☐ Do you smoke?

☐ Have you ever smoked? If so, when did you quit?

☐ Do you have diabetes?

☐ Do you have a family member who has had coronary or atherosclerotic disease prior to age 55?

☐ If you check yes to any of the following, please describe your pain on a scale of 1-10, with 1 being almost non existent and 10 being excruciating. Does it get more or less severe as the day goes on? When do you notice it? What really aggravates it? ☐ Do you have pain or discomfort in your back?

_____

☐ Do you have pain or discomfort in your knee? If so, right or left?

_____

☐ Do you have pain or discomfort in your shoulder? If so, right or left?

_____

☐ Do you have pain or discomfort in your elbow? If so, right or left?

_____

☐ Do you have pain or discomfort in your wrist? If so, right or left?

_____

☐ Do you have pain or discomfort in your ankle? If so, right or left?

_____

☐ Please list any and all supplements/vitamins that you are taking at the present time.

_____

☐ Have you ever torn ligaments or cartilage in your knees? If so, when? ☐ Have you ever had shoulder surgery? If so, when?

_____

☐ Have you ever had a neck injury, such as whiplash? If so, when?

☐ Have you ever been treated for a spinal disc injury? If so, when?

Do you ever experience tingling or numbness in your elbows or hands?

What is the present state of your general health?

_____

What regular physical activities do you do now?

_____

How often? _____For how long each session?_____

I, _____certify that I understand the foregoing questions and my answers are true and complete. I understand that this information is being provided as part of my initial consultation and may not be periodically updated.

I, _____assume the risk for any changes in my medical condition that might affect my overall ability to exercise.

_____ _____

Signature Date

If you answered "yes" to one or more questions and you have not recently done so, consult with your doctor before beginning an exercise program. Tell your doctor which questions you answered "yes" to and explain that you plan to undergo an exercise program that may include, but not be limited to, weight and/or resistance training. After medical evaluation, ask your doctor what activities you may safely participate in and what specific restrictions, if any, should apply to your condition.

I, _____acknowledge that I have read the foregoing statements and understand the content thereof.

_____ _____

Signature Date

MEDICAL RELEASE FORM
Personal Training

(Patients Name) _____has enrolled in a personal training program.

This activity involves: A fitness assessment, including body composition assessment, muscular endurance and flexibility tests, a blood pressure reading, cardiovascular fitness assessment and an exercise program. This exercise program will include, but not be limited to, resistance training. The sessions will last approximately one hour and will begin at a very moderate, sub maximal level.

Please complete the following:

I know no reason why the applicant may not participate.

I believe the applicant can participate, but I urge caution and recommend these modifications.

_____

_____

The applicant should not engage in the following activities.

_____

_____

I recommend that the applicant NOT participate.

Physicians Name (print): _____

Signature of Physician: _____ Date:_____

H/Fitness/Personal Training/Consultation Forms/Medical Release form pt

Name					Date			
Workout (Machines)								
Exercise	Seat Adjust	Set 1		Set 2		Set 3		Comments
		Rep.	Wt.	Rep.	Wt.	Rep.	Wt.	
Rotary Chest								
Rotary Upper Back								
Leg Press								
Leg Extensions								
Leg Curl								
Hyperextension								
Rotary Shoulder								
Triceps Extension								
Bicep Curl								
Prone Leg Curl								
Rotary Lat								
Abdominal								
Gravitron								
Pec Fly								
Rear Delt								
Vertical Butterfly								
Rotary Torso								

Cardio Workout							
Type							
Time							
Program							
Level							
Resistance							
RPM/SPM							
times per week							

Vital Statistics and Measurements							
Date	Start	Goal	Evaluation #2		Start	Goal	Evaluation #2

Height				Waist			
Weight				Chest			
Blood Pressure				Hips			
Routine Pulse				Biceps right/left			
Training HR				Thigh right/left			
% Body Fat							
# Lean Mass							
# Fat							

NutritionalAnalysis FoodLog

	Day1	Amount	Calories	Day2
Breakfast				
A.M.Snack				
Lunch				
P.M.Snack				
Dinner				
Beverage/ Snack				
TOTAL				

Amount	Calories

Day 3	Amount	Calories