YMCA OF THE UPPER PEE DEE

# PERSONAL TRAINING

## Participant Forms

Please complete this packet prior to your first training session.

Updated 7/24/23

# INFORMED CONSENT
## For Exercise Fitness Testing & Exercise Participation

I, _____desire to engage voluntarily in the YMCA exercise program, in order to attempt to improve my physical fitness. I understand that the activities are designed to place a gradually increasing workload on the cardiorespiratory and musculoskeletal systems and thereby attempt to improve their function. The reaction of these systems to such activities cannot be predicted with complete accuracy. There is a risk of certain changes that might occur during or following the exercise, including but not limited to abnormalities of blood pressure and heart rate.

I understand that the fitness-testing program is designed to evaluate cardiorespiratory fitness, body composition, flexibility, and muscular strength and endurance. These tests may include, but are not limited to, sub-maximal cardiorespiratory tests to predict aerobic capacity, static stretches to observe flexibility, and sub-maximal resistance to examine muscle strength and endurance. The results of your assessment are confidential and will be discussed with you only.

I understand that the purpose of a regular exercise program is to improve and maintain cardiorespiratory fitness, body composition, flexibility, and muscular strength and endurance. A specific exercise plan will be designed for me, based on my needs and interests and any recommendations provided by my physician. All programs are intended to place a gradually increasing workload on the body in order to improve overall fitness.

I understand that I am responsible for monitoring my own condition throughout the exercise program and should any unusual symptoms occur, I agree to cease active participation and inform the trainer of the symptoms.

In the event that medical clearance must be obtained prior to my participation, I agree to consult my physician and obtain written clearance or allow the YMCA to obtain such clearance.

Also, in consideration for being allowed to participate in the YMCA exercise program, I agree to assume the risk of such exercise, and further agree to hold harmless the YMCA and its staff members conducting the exercise program from any and all claims, suits, losses, or related causes of action for damages, including, but not limited to, such claims that may result from injury or death, accidental or otherwise, during or arising in any way from, the exercise program.

I understand that there is a 24 hour cancellation policy for all training sessions and if I fail to cancel within that time frame I will be charged for that training session.

_____

(Signature of participant) (Date)

_____

(Trainer administering program) (Date)

# HEALTH HISTORY

Name: _____ Date: _____

Email: _____

Address: _____

Phone: (H) _____ (C)_____

Age: _____ Birth date: _____

Height: _____ feet _____ in. Weight: _____lb.

Emergency Contact: _____

Emergency Contact Phone: _____

**PLEASE CHECK ALL THAT APPLY**

| | Client | Family | If yes, describe |
|---|---|---|---|
| Diabetes | _____ | _____ | _____ |
| High Blood Pressure | _____ | _____ | _____ |
| High Cholesterol | _____ | _____ | _____ |
| Smoke or use Tobacco | _____ | _____ | _____ |
| Angina/Chest Pain | _____ | _____ | _____ |
| Heart Murmur | _____ | _____ | _____ |
| Irregular Heart Beats | _____ | _____ | _____ |
| Abnormal ECG | _____ | _____ | _____ |
| Rheumatic Fever | _____ | _____ | _____ |
| Respiratory Infections | _____ | _____ | _____ |
| Asthma | _____ | _____ | _____ |
| Aneurysm | _____ | _____ | _____ |
| Stroke | _____ | _____ | _____ |
| Valve Disease | _____ | _____ | _____ |
| Heart Attack | _____ | _____ | _____ |

**Do you have any of the following conditions that may limit your physical activity?**
(please check if applicable)

__Arthritis
__Shoulder/Clavicle Injury
__Arm/Elbow Injury
__Calcium Deposits
__Upper Back Injury
__Ankle/Foot injury
__Low Back Pain
__Knee/Thigh Injury
__Nerve Damage
__Head/Neck Injury
__Bone Fracture
__Wrist/Hand Injury
__Hip/Pelvic Injury
__Tennis Elbow
__Other

If other please explain: _____

_____

_____

Has your physician ever advised against exercise? __Yes __No

Are you presently receiving physical therapy? __Yes __No

Are you presently taking any medications? __Yes __No

If yes, please list names and dosages of each: _____

_____

Do you currently smoke? __Yes __No

If yes, how many cigarettes/cigars per day? _____

Do you currently consume alcohol? __Yes __No

If yes, how many drinks per day? _____

Are you involved in an exercise program at the present time? __Yes __No

If yes, please describe the program: _____

_____

_____

How would you rate the amount of physical activity at work/home/school?

__Very little __Little __Moderate __Active __Very active

How would you rate the stress level of work/home/school?

__Little __Moderate __Stressful

Have you ever had a cardiovascular stress test? __Yes __No

If so, date of most recent test: _____

Results: __Normal __Abnormal

Do you follow any special diet at the present time? __Yes __No

If so, what type?

__Low cholesterol/low fat __Low salt

__Reduced calorie __Liquid Diet

__Other

If other, please specify: _____

_____

What are your personal exercise program goals?

__ Weight Control/loss
__ Staying in Shape
__ Cardiovascular Conditioning
__ Increasing Strength
__ Stress Reduction
__ Other

What are you currently doing for exercise?

__Cardiovascular (aerobic) – minutes/session_____ times/week_____

__Strength Training (weights) -mode/type_____

times/week_____

If you are currently taking classes or participate in other activities please list those below: _____

_____

_____

_____

# PERSONAL TRAINING PREFERENCES

We are committed to accommodating your requests and preferences below. Please be as specific as possible. This allows us easier allocation of the correct trainer based on your needs.

Name: _____ Phone: _____

E-mail: _____

**I am interested in (select one):**

One Personal Training session _____

3 Personal Training sessions _____

6 Personal Training sessions _____

12 Personal Training sessions _____

**I prefer (select one):**

Female trainer _____

Male trainer _____

No preference _____

If you have the name of a trainer you would like to request, please indicate here:

_____

**I would like to focus on (select one):**

Land exercise _____

Water exercise _____

Combination of water & land exercise _____

I am available for training: M T W TH F S Sun (check all that apply)

All hours available to train (please specify hours):

# PAR-Q and YOU (A Questionnaire for People Ages 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 to 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 are 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 (for example, back, neck, knee, or hip) 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 **any other reason** 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 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 activities 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 to you.

### 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 a fitness appraisal – this is an excellent way to determine your basic fitness so that you can plan the best way for you to live actively. It is also highly recommended that you have your blood pressure evaluated. If your reading is over 144/94, talk with your doctor before you start becoming much more physically active.

### DELAY BECOMING MUCH MORE ACTIVE:

- If you are not feeling well because of a temporary illness such as a cold or a fever – wait unit 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 you 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 completion of this questionnaire, consult your doctor prior to physical activity.

**NOTE:** If the PAR-Q is being given to a person before he or she participates in a physical activity program or a fitness appraisal, this section may be used for legal or administrative purposes.

"I have read, understood and completed this questionnaire. Any questions 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.

# PAR-Q+

## 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 exercise 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. | YES | NO |
|---|---|---|
| 1) Has your doctor ever said that you have a heart condition ☐ OR high blood pressure ☐? | ☐ | ☐ |
| 2) Do you feel pain in your chest at rest, during your daily activities of living, OR when you do physical activity? | ☐ | ☐ |
| 3) Do you lose balance because of dizziness OR have you lost consciousness in the last 12 months? Please answer NO if your dizziness was associated with over-breathing (including during vigorous exercise). | ☐ | ☐ |
| 4) Have you ever been diagnosed with another chronic medical condition (other than heart disease or high blood pressure)? PLEASE LIST CONDITION(S) HERE: _____ | ☐ | ☐ |
| 5) Are you currently taking prescribed medications for a chronic medical condition? **PLEASE LIST CONDITION(S) AND 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 CONDITION(S) HERE:** _____ | ☐ | ☐ |
| 7) Has your doctor ever said that you should only do medically supervised physical activity? | ☐ | ☐ |

**If you answered NO to all of the questions above, you are cleared for physical activity. Please sign the PARTICIPANT DECLARATION. You do not need to complete Pages 2 and 3.**

- Start becoming much more physically active – start slowly and build up gradually.
- Follow Global Physical Activity Guidelines for your age (https://apps.who.int/iris/handle/10665/44399).
- You may take part in a health and fitness appraisal.
- If you are over the age of 45 yr and NOT accustomed to regular vigorous to maximal effort exercise, consult a qualified exercise professional before engaging in this intensity of exercise.
- If you have any further questions, contact a qualified exercise professional.

**PARTICIPANT DECLARATION**

If you are less than 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 its records. In these instances, it will maintain the confidentiality of the same, complying with applicable law.

NAME _____ DATE _____

SIGNATURE _____ WITNESS _____

SIGNATURE OF PARENT/GUARDIAN/CARE PROVIDER _____

**If you answered YES to one or more of the questions above, COMPLETE PAGES 2 AND 3.**

**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 – answer the questions on Pages 2 and 3 of this document and/or talk to your doctor or a qualified exercise professional before continuing with any physical activity program.

# PAR-Q+

## 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 questions 1a-1c — If **NO** ☐ go to question 2

| | | |
|---|---|---|
| 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 spondylolysis/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 kind?**
   If the above condition(s) is/are present, answer questions 2a-2b — If **NO** ☐ go to question 3

| | | |
|---|---|---|
| 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 chemotheraphy 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 questions 3a-3d — If **NO** ☐ go to question 4

| | | |
|---|---|---|
| 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 currently have High Blood Pressure?**
   If the above condition(s) is/are present, answer questions 4a-4b — If **NO** ☐ go to question 5

| | | |
|---|---|---|
| 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 a resting blood pressure equal to or greater than 160/90 mmHg with or without medication? (Answer **YES** if you do not know your resting 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 5a-5e — If **NO** ☐ go to question 6

| | | |
|---|---|---|
| 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 of 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? | YES ☐ NO ☐ |

# PAR-Q+

**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, Down Syndrome

If the above condition(s) is/are present, answer questions 6a-6b If **NO** ☐ go to question 7

| | | |
|---|---|---|
| 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 a Respiratory Disease?** This includes Chronic Obstructive Pulmonary Disease, Asthma, Pulmonary High Blood Pressure

If the above condition(s) is/are present, answer questions 7a-7d If **NO** ☐ go to question 8

| | | |
|---|---|---|
| 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 ever 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, laboured 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 8a-8c If **NO** ☐ go to question 9

| | | |
|---|---|---|
| 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 9a-9c If **NO** ☐ go to question 10

| | | |
|---|---|---|
| 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 or muscles in the past 6 months? | YES ☐ NO ☐ |

**10.** **Do you have any other medical condition not listed above or do you have two or more medical conditions?**

If you have other medical conditions, answer questions 10a-10c If **NO** ☐ read the Page 4 recommendations

| | | |
|---|---|---|
| 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.**

# PAR-Q+

**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 yr 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 program.

- 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 physical activity.

## PARTICIPANT DECLARATION

- All persons who have completed the PAR-Q+ please read and sign the declaration below.
- If you are less than 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 _____ WITNESS _____

SIGNATURE OF PARENT/GUARDIAN/CARE PROVIDER _____

For more information, please contact

**www.eparmedx.com**
**Email: eparmedx@gmail.com**

**Citation for PAR-Q+**
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The PAR-Q+ was created using the evidence-based AGREE process (1) by the PAR-Q+ Collaboration chaired by Dr. Darren E. R. Warburton with Dr. Norman Gledhill, Dr. Veronica Jamnik, and Dr. Donald C. McKenzie (2). Production of this document has been made possible through financial contributions from the Public Health Agency of Canada and the BC Ministry of Health Services. The views expressed herein do not necessarily represent the views of the Public Health Agency of Canada or the BC Ministry of Health Services.

**Key References**

1. Jamnik VK, Warburton DER, Makarski J, McKenzie DC, Shephard RJ, Stone J, and Gledhill N. Enhancing the effectiveness of clearance for physical activity participation; background and overall process. APNM 36(S1):S3-S13, 2011.
2. Warburton DER, Gledhill N, Jamnik VK, Bredin SSD, McKenzie DC, Stone J, Charlesworth S, and Shephard RJ. Evidence-based risk assessment and recommendations for physical activity clearance; Consensus Document. APNM 36(S1):S266-s298, 2011.
3. Chisholm DM, Collis ML, Kulak LL, Davenport W, and Gruber N. Physical activity readiness. British Columbia Medical Journal. 1975;17:375-378.
4. Thomas S, Reading J, and Shephard RJ. Revision of the Physical Activity Readiness Questionnaire (PAR-Q). Canadian Journal of Sport Science 1992;17:4 338-345.