



Personal Training Pre-Participation Health Screening

This form must be filled out prior to any purchase of Personal Training sessions or packages. Once this form is completed it will be turned into the Fitness Supervisor who will then have a Trainer contact you within three business days. Your first meeting with your Trainer will be a FREE consultation in order to decide how many sessions you need in regards to your goals as well as obtain a Physician's Clearance if necessary.

General Information

First Name: _____ Last Name: _____ Date: _____

Address: _____ City, State, Zip: _____

Sex: _____ Age: _____ Birth date: _____

Home Phone #: () _____ Work Phone #: () _____ Email: _____

In Case of Emergency, notify: _____ Relationship: _____

Emergency Contact Phone #: _____

Days/Times Available: _____

What type of sessions would you like?

_____ One ½ Hour _____ One 1 Hour _____ One Hour Package _____ ½ Hour Package
_____ 6-Week Shape-Up _____ Group Training _____ Fitness Assessment
_____ Other: _____

What type of training are you looking for a trainer to assist you with?

_____ Cardiovascular _____ Strength _____ Sports Specific _____ Core
_____ Flexibility _____ Balance _____ Weight-Loss _____ Event
_____ Other: Please Specify: _____

Trainer Preference: Male/Female or Name if applicable (See Trainer Bios
Upstairs): _____

Health History

	YES	NO
1. Have you had any heart problems? Please specify:	Y	N
___ Congenital heart disease ___ Heart Attack		
___ Heart valve disease ___ Cardiac catheterization		
___ Heart surgery ___ Coronary angioplasty		
___ Heart transplantation ___ Pacemaker/ implantable cardiac		
___ Heart failure defibrillator/ rhythm disturbance		
2. Do you experience chest discomfort with exertion?	Y	N
3. Do you experience unreasonable breathlessness?	Y	N
4. Do you experience unexplained dizziness, fainting, or blackouts?	Y	N
5. Do you experience unexplained ankle swelling?	Y	N
6. Do you experience unpleasant awareness of a forceful or rapid heart rate?	Y	N
7. Do you take prescription medications?	Y	N
8. Do you have diabetes or pre-diabetes?	Y	N
9. Do you have asthma or other lung disease?	Y	N
10. Do you have musculoskeletal problems that limit your physical activity?	Y	N
11. Do you have burning or cramping sensation in your lower legs when walking short distances?	Y	N
12. Do you have concerns about the safety of exercise?	Y	N
13. Are you pregnant?	Y	N
14. 12. Are you a man ≥ 45 years?	Y	N
15. 13. Are you a woman ≥ 55 years?	Y	N
16. Do you smoke, or did you quit smoking within the previous 6 months?	Y	N
17. Is your blood pressure $\geq 140/90$ mmHg?	Y	N
18. Is your blood cholesterol level ≥ 200 mg/dL?	Y	N
19. Do you have a close blood relative who had a heart attack or heart surgery before age 55 (father or brother) or age 65 (mother or sister)?	Y	N
20. Are you physically inactive? (i.e. you get less than 30 minutes of physical activity on at least 3 days per week)	Y	N