PERSONAL TRAINING SERVICES
NEW CLIENT REGISTRATION FORM

STAFF USE ONLY
Accepted by (print name)

Amount Paid:_____

Trainer:_____

ACSM HEALTH STATUS & HEALTH HISTORY QUESTIONNAIRE

This form includes several questions regarding your physical health – please answer every question as accurately as possible. Please ask us if you have any questions. Your responses will be treated in a confidential manner.

PERSONAL INFORMATION

Today's Date:

Last Name:_____ First Name: _____ Gender: F M

Phone:_____ Email:_____

Ethnicity: *(check all that apply)*
□ American Indian/Alaska native □ Asian □ Black or African-American
□ Caucasian/European □ Hispanic/Latino □ Native Hawaiian/Pacific Islander

Date of Birth_____/_____/_____ Age_____ Height _____ Weight _____

Emergency Contact:_____

Physician's Name and Phone:

YES NO (ACSM HEALTH SCREEN)

☐ ☐ Do you have any personal history of heart disease (coronary or atherosclerotic disease)?

☐ ☐ Any personal history of diabetes or other metabolic disease (thyroid,renal,liver)?

☐ ☐ Any personal history of pulmonary disease, asthma, interstitial lung disease or cystic fibrosis?

☐ ☐ Have you experienced pain or discomfort in your chest apparently due to blood flow deficiency?

☐ ☐ Any unaccustomed shortness of breath (perhaps during light exercise)?

☐ ☐ Have you had any problems with dizziness or fainting?

☐ ☐ Do you have difficulty breathing while standing or sudden breathing problems at night?

☐ ☐ Have you experienced a rapid throbbing or fluttering of the heart?

☐ ☐ Do you suffer from ankle edema (swelling of the ankles)?

☐ ☐ Have you experienced severe pain in leg muscles during walking?

☐ ☐ Do you have a known heart murmur?

☐ ☐ Has your serum cholesterol been measured at greater than 200 mg/dl?

☐ ☐ Are you a cigarette smoker?

☐ ☐ Has your HDL (the "good" cholesterol) been measured at greater than 60 mg/dl?

☐ ☐ Would you characterize your lifestyle as "sedentary"?

☐ ☐ Have you had a high fasting blood glucose level on 2 or more occasions (>=110mg/dl)?

☐ ☐ Are you 20% or more overweight or have you been told your “BMI” was greater than 30?

☐ ☐ Have you been assessed as hypertensive on at least 2 occasions (systolic > 140mmHg or diastolic > 90mmHg)?

☐ ☐ Do you have any family history of cardiac or pulmonary disease prior to age 55?

MEDICAL HISTORY

☐ Are you currently being treated for high blood pressure?

If you know your average blood pressure, please enter:_____/_____

Please check all conditions or diagnoses that apply:

☐ Abnormal EKG?	☐ Limited Range of Motion?	☐ Stroke?
☐ Abnormal Chest X-Ray?	☐ Arthritis?	☐ Do You Suffer from Epilepsy or Seizures?
☐ Rheumatic Fever?	☐ Bursitis?	☐ Chronic Headaches or Migraines?
☐ Low Blood Pressure?	☐ Swollen or Painful Joints?	☐ Persistent Fatigue?
☐ Asthma?	☐ Foot Problems?	☐ Stomach Problems?
☐ Bronchitis?	☐ Knee Problems?	☐ Hernia?
☐ Emphysema?	☐ Back Problems?	☐ Anemia?
☐ Other Lung Problems?	☐ Shoulder Problems?	☐ Are You Pregnant?
	☐ Recently Broken Bones?	

☐ Has a doctor imposed any activity restrictions? If so, please describe:

_____

_____

FAMILY HISTORY

Have your mother, father, or siblings suffered from (please select all that apply):

- ☐ Heart attack or surgery prior to age 55.
- ☐ Stroke prior to age 50.
- ☐ Congenital heart disease or left ventricular hypertrophy.
- ☐ Hypertension
- ☐ Leukemia or cancer prior to age 60.
- ☐ High cholesterol
- ☐ Diabetes
- ☐ Obesity
- ☐ Asthma
- ☐ Osteoporosis

MEDICATIONS

Please Select Any Medications You Are Currently Using:

☐ Diuretics	☐ Other Cardiovascular
☐ Beta Blockers	☐ NSAIDS/Anti-inflammatories (Motrin, Advil)
☐ Vasodilators	☐ Cholesterol
☐ Alpha Blockers	☐ Diabetes/Insulin
☐ Calcium Channel Blockers	☐ Other Drugs (record below).

Please list the specific medications that you currently take:

_____

_____

_____

LIFESTYLE

☐ Are you a cigarette smoker? If so, how many per day? _____

☐ Previously a cigarette smoker? If so, when did you quit? _____

How many years have you smoked or did you smoke before quitting? _____

Do you/did you smoke (Circle one): Cigarettes Cigars Pipe

Please Rate Your Daily Stress Levels (select one):

☐ Low ☐ Moderate ☐ High but I enjoy the challenge ☐ High: sometimes difficult to handle ☐ High: often difficult to handle.

☐ Do you drink alcoholic beverages?

How many units of alcohol do you consume per week:_____(see Alcohol Units Chart)

Alcohol Units Table

Type of Drink	Units
½ pint of beer	1
1 glass of wine	1
1 pub measure of spirits (Gin, Vodka etc.)	1
1 can of beer	1.5
1 bottle of strong lager	2.5
1 can of strong lager	4
1 bottle of wine	7
1 litre bottle of wine	10
1 bottle of fortified wine (port, sherry etc.)	14
1 bottle of spirits	30

Dietary Habits. Please Select All That Apply.

☐ I seldom consume red or high-fat meats.

☐ I pursue a low-fat diet.

☐ My diet includes many high-fiber foods.

☐ I eat at least 5 servings of fruits/vegetables per day.

☐ I almost always eat a full, healthy breakfast.

☐ I rarely eat high-sugar or high-fat desserts.

OTHER HEALTH HISTORY INFORMATION

Please indicate any other medical conditions or activity restrictions that you may have, or any other information you feel is critical to understanding your readiness for exercise. It is important that this information be as accurate and complete as possible

_____

_____

HEALTH AND FITNESS GOALS

Pleasee indicate your personal health and fitness-related goals (select all that apply):

☐ Cardiovascular Fitness	☐ Injury Rehab	☐ Muscular Strength
☐ Feel Better	☐ Look Better	☐ Reduce Stress
☐ General Fitness	☐ Lose Weight	☐ Reduce Back Pain
☐ Improve Diet	☐ Lower Cholesterol/Blood Pressure	☐ Sport-Specific Training
☐ Improve Flexibility	☐ Muscular Size	☐ Stop Smoking

Pleasee tell us a little about your exercise patterns and goals:

What is your exercise history?

What health improvements do you need?

What are your activity preferences?

What barriers to success do you anticipate?

How will you know that you are succeeding?

What is your *motivation* level? □ High □ Medium □ Low

What is your *confidence* level? □ High □ Medium □ Low

Please use the space below to record three specific commitments that you are willing to make to your own health and fitness goals. For example, you might commit "to arrive, ready for exercise, on Mondays, Wednesdays, and Fridays by 6:30p.m." Your commitments should be challenging, but also realistic and attainable. When finished, please sign this form to signify your personal commitment.

Commitment #1: _____

Commitment #2: _____

Commitment #3: _____

_____	_____	_____
Printed Name	Signature	Date

Services Purchased (select all that apply)

- **Marshall Health Fitness Program**: _____
- **Personal Training**:_____Individual Partner Group

  1 Session 5 Sessions 10 Sessions

  Your partner's or group's name(s), if applicable: _____

- **Nutrition Consultation**:_____
- **Fitness Assessment** (Included in 5 or 10 session package):_____
- **Fitness Consultation** (evaluation of your current exercise program only): _____

CANCELLATION NOTICE

24 hour notice is required for session cancellation.

We reserve the right to charge for appointments cancelled or broken without 24 hours advance notice.

LATE POLICY

If a client is late for a session, it will still end one hour after the scheduled start time.

REFUND POLICY

All packages are nonrefundable, nontransferable, and expire one year from initial date of use.

I have carefully read and understand the above information. The policies have been explained to me by the Campus Recreation staff and any questions have been answered to my satisfaction.

Signature: _____ **Date:** _____