

Date: _____



DEPARTMENT OF
Wellness

For Office Use Only:
Receipt Attached _____

SMALL GROUP TRAINING QUESTIONNAIRE

First Name: _____ Last Name: _____

Address 1: _____

Address 2: _____

City, State, Zip: _____ Date of Birth: ____/____/____

Phone # _____ Email: _____ CWID: _____

Affiliation: Undergrad Graduate/Doctorate Faculty/Staff Alumni Other: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Method of payment: Cash _____ Check _____ Bursar Account _____ Credit Card _____

- 1.) Please describe your current and/or previous exercise experience:
- 2.) How many sessions per week would you like to meet with your trainer? 2 _____ or 3 _____
- 3.) Do you plan to exercise in addition to personal training sessions? If so, how many times per week? _____
- 4.) Are you currently taking any over-the-counter or prescription medications or drugs? If so, please list:
- 5.) What are your health and fitness goals? (Check all that apply)
 - Weight Loss Cardiovascular Exercise Muscle Strength and Endurance Flexibility
 - Other _____
- 6.) Do you prefer working with a: Male Trainer Female Trainer No Preference
- 7.) Do you have a specific trainer in mind? Yes No If yes, please specify. _____
- 8.) Please list the additional participants in your Small Group Training program:

Note: Small Group Training sessions are **non-refundable**

Check preferred days/times	Early Morning 6-8 am	Mid-Morning 9-11 am	Early Afternoon 12-2 pm	Mid-Afternoon 3-5 pm	Early Evening 6-8 pm	Late Evening 9 pm-12 am
MONDAY						
TUESDAY						
WEDNESDAY						
THURSDAY						
FRIDAY						
SATURDAY						
SUNDAY						

Physical Activity Readiness Questionnaire (American College of Sports Medicine, 1998): Check the appropriate box on each question. A physician's release will be required if you answer "yes" to any item listed in the box below.

YES NO

- | | | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Has your doctor ever said that you have a heart condition <u>and</u> that you should only do physical activity recommended by a doctor? |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Do you feel pain in your chest when you do physical activity? |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. In the past month, have you had chest pain when you were not doing physical activity? |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. Do you lose your balance because of dizziness or do you ever lose consciousness? |
| <input type="checkbox"/> | <input type="checkbox"/> | 5. Do you have a bone or joint problem that could be made worse by a change in your physical activity? |
| <input type="checkbox"/> | <input type="checkbox"/> | 6. Is your doctor currently prescribing drugs (for example, water pills) for your blood pressure or heart condition? |
| <input type="checkbox"/> | <input type="checkbox"/> | 7. Do you know of <u>any other reason</u> why you should not do physical activity? |

Additional Information: Please mark all that apply.

- | | |
|--------------------------|---|
| <input type="checkbox"/> | 1. Smoke or quit smoking in the last 3 months |
| <input type="checkbox"/> | 2. Taking medication for high blood pressure |
| <input type="checkbox"/> | 3. Hernia or other condition that may be aggravated by lifting weights |
| <input type="checkbox"/> | 4. Diabetes |
| <input type="checkbox"/> | 5. Recent surgery (last 12 months) Explain: |
| <input type="checkbox"/> | 6. Pregnancy (now or within the last 3 months) |
| <input type="checkbox"/> | 7. Pre-existing injuries or physical restrictions that may limit your ability to exercise. If so, please explain: |

RELEASE AND INDEMNITY AGREEMENT:

I hereby release the Board of Regents of Oklahoma State University and all its employees from all claims on account of injury which may be sustained while attending this class, and I agree to indemnify the Board of Regents of Oklahoma State University and its employees for any claim which may hereafter be presented as a result of such injuries.

Print Name _____

Signature _____ **Date** _____

PHYSICIAN'S STATEMENT AND CLEARANCE FORM

At the Department of Wellness, your safety is our primary concern. For this reason, we comply with the health and fitness standards of the American College of Sports Medicine.

On the Physical Activity Readiness Questionnaire (PAR-Q), you identified that you have one or more coronary and/or other medical risk factors which may impair your ability to exercise safely. For this reason, you need to have a physician complete and return this medical clearance form before you can begin exercising at the Seretean Wellness Center or the Colvin Recreation Center.

We recognize that you are eager to start your fitness program, and we sincerely regret any inconvenience that this may cause you. However, please keep in mind that we want your exercise experience to be as safe as possible.

Please ask your physician to complete the bottom portion of this form. He/she may fax the form back to us at the number listed below.

I hereby give my physician permission to release any pertinent medical information from any medical records to the staff at the Department of Wellness. All information will be kept confidential.

Patient's name (type or print) _____ DOB _____

Patient's signature: _____ Date: _____

Reason for medical clearance _____

Physician's name _____ Phone _____ Fax _____

FOR PHYSICIAN USE ONLY

Please check one of the following statements:

- I concur with my patient's participation with no restrictions
- I concur with my patient's participation in an exercise program with the following restrictions:

- I **do not** concur with my patient's participation in an exercise program with the Department of Wellness.

Reason _____

Physician's name (type or print) _____

Physician's signature _____ Date _____

PLEASE RETURN COMPLETED FORM TO:
Colvin Recreation Center Business Office (101)
or
Seretean Wellness Center Front Desk