



Small Group Training Questionnaire

Client Information

Last Name: _____ First Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: ____/____/____

Phone #: _____ E-mail: _____ CWID: _____

OSU Affiliation: Undergraduate __ Graduate __ Faculty/Staff __ Other __

Method of payment: Cash__ Check__ Bursar account__ Credit Card__

Emergency Contact Information:

Name: _____ Relationship: _____

Phone #: _____ E-mail: _____

Please list the other participants in your small group:

- | | |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | |

How many sessions would your group like to purchase?

- Do you prefer working with a _____
- If you prefer a particular trainer, please specify: _____
- Would you prefer to meet with your trainer _____ days per week?
- Would you like to work with an *IFIT certified trainer? Y N

***IFIT trainers are qualified to work with a variety of disabilities including ALS, amputation, arthritis, cerebral palsy, diabetes, fibromyalgia, hearing or visual impairment, multiple sclerosis, muscular dystrophy, osteoporosis, Parkinson's disease, spina bifida, and spinal cord injury.**

Availability: Please mark days and times that your group is available to meet with a trainer.

	Sun.	Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.
5:30 - 8:30am							
8:30 - 11:30am							
11:30am - 2:30pm							
2:30 - 5:30pm							
5:30 - 8:30pm							
8:30pm - Midnight							

Please return to the Colvin Business Office or email to fitness@okstate.edu



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Fitness History and Goals: (Please be as detailed as possible.)

1. Please describe your current and/or previous exercise experience:

2. Do you plan to exercise in addition to personal training sessions? **Y** **N** If yes, how many times per week? _____
3. What primary health goals would you like your program to focus on? (Please choose all that apply):
Weight loss **Cardiovascular Endurance** **Muscular strength** **Flexibility**
Muscular Endurance **Balance/Stability** **Other:**_____
4. Please specify any forms of exercise you know you cannot do.

5. Have you ever begun an exercise program but not followed through? If so, what were contributing factors to not finishing the program? _____
6. Do you smoke or have you quit smoking in the last 3 months? **Y** **N**
7. Do you have a hernia/other condition that could be aggravated by lifting weights? **Y** **N**
8. Are you currently pregnant or less than 3 months postpartum? **Y** **N**

Physical Activity Readiness Questionnaire (PAR-Q+, OSHF, 2017)

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) BELOW:		
5. Are you currently taking prescribed medications for a chronic medical condition? PLEASE LIST MEDICATION(S) AND CONDITION(S) BELOW:		
6. Do you currently have (or have had in the past 12 months) a bone, joint, or soft tissue (muscle, tendon, or ligament) 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) BELOW:		
7. Has your doctor ever said that you should only do medically supervised physical activity?		

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If you answered “no” to all of the previous questions, you are cleared for physical activity without medical clearance. You may skip to the last page and sign the agreement. If you answered “yes” to ANY of the previous questions, you will need to obtain medical clearance from your physician before participating in a personal training program.

If you answered “yes” to ANY of the above questions, please complete the following questions.

Please read the 7 questions below carefully and answer each one honestly: check YES or NO.	YES	NO
Do you have arthritis, osteoporosis, or back problems? PLEASE SPECIFY CONDITION(S):		
Do you currently have cancer of any kind? PLEASE SPECIFY BELOW:		
Are you receiving radiotherapy or chemotherapy?		
Do you have a heart condition that is difficult to control with medication or other physician-prescribed therapies? PLEASE SPECIFY CONDITION(S):		
Do you have Type I or Type II Diabetes, Pre-diabetes, or any other metabolic condition? PLEASE SPECIFY CONDITION(S):		
Do you have asthma or any other respiratory condition? PLEASE SPECIFY CONDITION(S):		
Have you ever had a spinal cord injury?		
Have you ever had a stroke?		
Please list any other medical conditions you may have that are not included in this form.		

Cancellation Policy: The client must notify the trainer at least 24 hours prior to the session if he/she wishes to cancel or reschedule. If the client does not notify the trainer at least 24 hours prior to the session, he/she may knowingly forfeit that session and will not be eligible for a refund.

Expiration Notice: All small group training sessions will expire one year from date of purchase. If the client does not use all of their sessions within that year, he/she knowingly forfeits the remaining sessions and will not be eligible for a refund. All Small Group training sessions are NON-REFUNDABLE.

Release and Indemnity Agreement: I hereby release the Board of Regents at Oklahoma State University and all its employees from all claims on account of injury which may be sustained while participating in this program, 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: _____

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