FITNESS

Personal 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:_____

1. If applicable, please specify the name of your training partner for **Buddy Personal Training**: _____
2. How many days per week would you like to meet with your trainer? ___
3. Do you prefer working with a male __ or female __ trainer?
4. If you prefer a particular trainer, please specify: _____
5. 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 you ARE 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. Do you have a hernia/other condition that could be aggravated by lifting weights? **Y ___ N ___**
4. Have you ever begun an exercise program but not followed through? If so, what were contributing factors to not finishing the program? _____
5. What primary health goals would you like your program to focus on?

   Weight loss ☐ **Cardiovascular Endurance** ☐ **Muscular strength** ☐ **Flexibility** ☐
   Muscular Endurance ☐ **Balance/Stability** ☐ **Other:**_____
6. Please specify any forms of exercise you know you cannot do.

   _____
7. Do you smoke or have you quit smoking in the last 3 months? **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 above questions, you will need to obtain medical clearance from your physician before participating in a personal training program.

If you answered "yes" to ANY question, 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 personal training sessions will expire exactly one year after the date on which they were purchased. If the client does not use all of their sessions within one year, he/she knowingly forfeits the remaining sessions and will not be eligible for a refund.

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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