PERSONAL TRAINING
CLIENT PACKET

Dear Participant:

Thank you for your interest in the West River Community Center Personal Training Program. It is our mission to provide you with first class instruction and personal training designed to achieve your personal fitness goals.

This packet includes information on your health history, your exercise history and goals and expected trainer/client conduct. It should be completed entirely and brought with you to your initial consultation. The information in this packet will help your personal trainer to develop a program specifically tailored for you; therefore, it is important to answer all questions thoroughly and honestly. All information will be kept confidential and will be discussed further with your trainer at your first meeting.

Forms to be completed before your first meeting with your personal trainer:

- Completion of PAR-Q (1 page) and Health History Form (3 pages)
- Medical Release Form (if necessary)
    - The Medical Release Form is required if you answer "yes" to any question on the PAR-Q and may be required if your trainer determines you are at a higher risk based on information provided on your Health History Form.
    - Attainment of medical release will be organized by your trainer and discussed at your initial meeting.
- Completion of Exercise History and Goals Worksheet (2 pages)
- Reading and signing the Personal Trainer and Client Code of Conduct
- Completion of Assumption of Risk Agreement

If you have any questions or concerns, please contact Matt Mack at (701) 456-2074.

Thank you,

Facility Operations Manager
Dickinson Parks and Recreation

Physical Activity Readiness
Questionnaire - PAR-Q

PAR-Q

(A Questionnaire for People Aged 15 to 69)

Regular physical activity is fun and healthy, and increasingly more people are starting to become more active every day. Being more active is very safe for most people. However, some people should check with their doctor before they start becoming much more physically active.

If you are planning to become much more physically active than you are now, start by answering the seven questions in the box below. If you are between the ages of 15 and 69, the PAR-Q will tell you if you should check with your doctor before you start. If you are over 69 years of age, and you are not used to being very active, check with your doctor.

Common sense is your best guide when you answer these questions. Please read the questions carefully and answer each one honestly: check YES or NO.

YES	NO	
☐	☐	**1. Has your doctor ever said that you have a heart condition and that you should only do physical activity recommended by a doctor?**
☐	☐	**2. Do you feel pain in your chest when you do physical activity?**
☐	☐	**3. In the past month, have you had chest pain when you were not doing physical activity?**
☐	☐	**4. Do you lose your balance because of dizziness or do you ever lose consciousness?**
☐	☐	**5. Do you have a bone or joint problem (for example, back, knee or hip) that could be made worse by a change in your physical activity?**
☐	☐	**6. Is your doctor currently prescribing drugs (for example, water pills) for your blood pressure or heart con-dition?**
☐	☐	**7. Do you know of any other reason why you should not do physical activity?**

If you answered YES to one or more questions, please read and initial in box

Talk with your doctor by phone or in person BEFORE you start becoming much more physically active or BEFORE you have a fitness appraisal. Tell your doctor about the PAR-Q and which questions you answered YES.

- You may be able to do any activity you want — as long as you start slowly and build up gradually. Or, you may need to restrict your activities to those which are safe for you. Talk with your doctor about the kinds of activities you wish to participate in and follow his/her advice.
- Find out which community programs are safe and helpful for you.

Initial (if YES to any question) _____

NO to all questions

If you answered NO honestly to all PAR-Q questions, you can be reasonably sure that you can:

- start becoming much more physically active – begin slowly and build up gradually. This is the safest and easiest way to go.
- take part in a fitness appraisal – this is an excellent way to determine your basic fitness so that you can plan the best way for you to live actively. It is also highly recommended that you have your blood pressure evaluated. If your reading is over 144/94, talk with your doctor before you start becoming much more physically active.

DELAY BECOMING MUCH MORE ACTIVE:

- if you are not feeling well because of a temporary illness such as a cold or a fever – wait until you feel better; or
- if you are or may be pregnant – talk to your doctor before you start becoming more active.

PLEASE NOTE: If your health changes so that you then answer YES to any of the above questions, tell your fitness or health professional. Ask whether you should change your physical activity plan.

Informed Use of the PAR-Q: The West River Community Center, Dickinson Parks and Recreation and their agents assume no liability for persons who undertake doubt after completing this questionnaire, consult your doctor prior to physical activity.

"I have read, understood and completed this questionnaire. Any questions I had were answered to my full satisfaction."

NAME _____

SIGNATURE _____ DATE _____

SIGNATURE OF PARENT OR GUARDIAN _____

(for participants under the age of 18 years)

Note: This physical activity clearance is valid for a maximum of 12 months from the date it is completed and becomes invalid if your condition changes so that you would answer YES to any of the seven questions.

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Medical Release Form

- **If you answered "yes" to any of the questions on the PAR-Q form, it is required that you have a medical release completed by your physician before a trainer begins any fitness regimen with you.**
- **Your trainer may also require that a Medical Release Form be completed before beginning any fitness regimen with you if your health history indicates any higher risk conditions. If necessary, this will be discussed in greater detail during your initial consultation.**

Dear Doctor:

Your patient,_____, wishes to start a personalized fitness program with a Personal Trainer from the West River Community Center.

The activity will involve but is not limited to: regular cardiorespiratory activity and regular resistance training which will elevate his/her heart rate and blood pressure.

If your patient is taking medication that will affect his/her heart rate response to exercise, please indicate the manner of the effect (raises, lowers, or has no effect on heart-rate response):

Type of medication(s)_____

Effect(s)_____

Please identify any other recommendations or restrictions for your patient in this exercise program:

_____

_____

_____

_____(Clients full name) has my approval to begin an exercise program with the recommendations or restrictions stated above.

Printed name_____Phone_____

Signed_____Date _____

Thank you,
Matt Mack
Facility Operations Manager
Dickinson Parks and Recreation
Office: (701) 456-2074 Fax: (701) 456-2073

West River Community Center

PERSONAL TRAINING CLIENT PACKET

Health History and Personal Information

Name:_____

Address:_____ City/State/Zip:_____

Phone:_____ Email:_____

Birthdate:_____ Age:_____ Gender: _____

Marital Status: Single Married Divorced Separated Widowed

Number of Children:_____

Occupation:_____ Full Time or Part Time

Occupation of Spouse:_____ Full Time or Part Time

Medical History

Height:_____ Current Weight: _____

Primary Health Care Provider:_____

Address:_____ City/State/Zip:_____

1. Please check all conditions you currently have or have had in the past:

- ☐ Heart Attack
- ☐ Asthma
- ☐ Stroke
- ☐ Chest discomfort while physically active
- ☐ Chest discomfort while physically inactive
- ☐ Heart Murmur
- ☐ Migraine or Headache
- ☐ Neck problems
- ☐ Back problems
- ☐ Broken Bones
- ☐ Shortness of Breath
- ☐ Swelling of Joints
- ☐ Anemia
- ☐ Thyroid Condition
- ☐ Recent Surgery (last 12 months)
- ☐ Epilepsy
- ☐ Anxiety or Depression
- ☐ Fatigue
- ☐ Hernia
- ☐ Stomach problems
- ☐ Limited range of motion
- ☐ Arthritis
- ☐ History of heart problems in immediate family
- ☐ Loss of consciousness
- ☐ Dizziness

Please explain any conditions that you checked (i.e. treatment, symptoms, restrictions):

_____

_____

_____

2. Do you currently smoke or did you quit smoking within last 6 months? YES or NO
   If yes, how often do you smoke or how long ago did you quit?_____
   _____
3. Have you been diagnosed with high or low blood pressure by your doctor? YES or NO
   If yes, what were the last 3 readings? _____/_____; _____/_____; _____/_____
4. Have you been told you have high cholesterol levels by your doctor? YES or NO
   If yes, please list cholesterol levels and any interventions currently being used to manage your cholesterol:_____
   _____
5. Are you pregnant or post-partum? YES or NO - If yes, how many months are you?_____
6. Do you have diabetes (Type 1 or 2)? YES or NO
   If yes, please explain:_____
   _____
7. Do you have any injuries or orthopedic problems (bursitis, bad back, bad knees, etc.)? YES or NO
   If yes, please explain:_____
   _____
8. Are you taking any medications (prescribed or not)? YES or NO
   Please list and explain:_____
   _____
   _____
9. When were you last seen by a physician?_____
10. Have you ever been advised NOT to exercise by a physician? YES or NO
    If yes, please explain:_____
    _____
    _____
11. Are there any other medical conditions or problems (past or present) not previously mentioned in this form that we should know about, or that may affect your ability to begin an exercise program?
    If yes, please explain:_____
    _____
    _____

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Consent Form

I acknowledge that I am in good health, have answered the previous questions truthfully, and have no known medical problems that would restrict my ability to participate in this exercise program.

Participant Name (printed):_____

Participant Signature:_____Date:_____

Parent or Guardian Signature (if under 18 years):_____

Personal Trainer Request

Do you have a particular trainer that you'd like to work with? If so, please write their name in the provided blank. All attempts will be made to schedule you with the trainer of your choice, however all requests will also be based on yours and the personal trainers daily schedules and available time, so it is not guaranteed that you'll be paired with whom you request. If you do not have a preference, you may leave this blank empty.

Personal Trainer Requested:_____

□ Male Personal Trainer Requested
□ Female Personal Trainer Requested

Services Requested

Please check the boxes of what services you're interested in receiving. You will only be contacted by who you check.

□ Only Personal Training for now.
□ Only Dietitian Services for now.
□ I want to sign up for both services.

Exercise History, Lifestyle & Goals

1. Check which apply:
   - □ I currently exercise.
   - □ I do not currently exercise and have never exercised regularly in the past.
   - □ I used to be active, but am not anymore. I would like to become active again.

If you do currently exercise, list those activities in which you participate and how much time you spend doing each per week._____

_____

_____

If you do not currently exercise, why not? (perceived barriers, unsure of what to do, etc.)

_____

_____

2. List any exercise, sport, or recreational activities in which you have participated:
   a) In the past 6 months: _____
   b) In the past 5 years: _____

3. How hard do you want to be pushed during exercise? (1 = easy, 5 = really hard)
   1 2 3 4 5

4. How much time are you willing to devote to an exercise program?
   Minutes per day_____ Days per week _____

5. Based on your personal schedule, what are the best days during the week for you to commit to an exercise program? M T W TH F S SU

6. What time of day are you available/do you prefer to meet with a personal trainer?
   - □ Early Morning Time preference:_____
   - □ Morning Time preference:_____
   - □ Afternoon Time preference:_____
   - □ Evening Time preference:_____
   - □ I'm available anytime

7. What is your current stress level? (1 = extremely low, 5 = extremely high)
   1 2 3 4 5

8. What are 3 main causes of your stress?

   1._____ 2. _____ 3. _____

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Please use the following scale to answer questions 9 and 10.

1	2	3	4	5	6	7	8	9	10
Not at all Important/Interesting				Somewhat Important/Interesting				Extremely Important/Interesting	

9. Rate the importance of each of the following exercise benefits to you:

___ Improve cardiovascular fitness
___ Increase muscular strength
___ Body fat/weight loss
___ Reshape or tone my body
___ Improve performance for a specific sport
___ Improve mood/feel better
___ Improve speed, agility, and power
___ Other _____

___Improve flexibility
___Improve balance
___Increase energy
___Decrease stress
___Enjoyment
___Social interaction

10. Rate your interest level in each of the following types of physical activity:

___ Weight Machines
___ Free Weights/Dumbbells
___ Cardio Equipment
___ Group X Classes
___ Other _____

___Running
___Swimming
___Cycling
___Walking

___Yoga
___Dance
___Martial Arts
___Team Sports

11. How many meals and/or snacks do you have per day?_____

12. Do you feel you eat healthy most of the time? Yes or No
Please check all that apply:

___ I pursue a diet that is high in unprocessed foods.
___ I eat at least 5 servings of fruits/vegetables every day.
___ I almost always eat a full, healthy breakfast.
___ I rarely eat high-sugar or high-fat desserts.
___ I seldom consume red meats.

13. How many glasses of water do you drink per day?

□ 0-2 □ 3-5 □ 6-8 □ 9-12 □ > 12

14. Please write down your primary health/fitness goal for the next (complete with trainer):

a) 1 month: _____

b) 6 months: _____

c) 1 year: _____

Weight/Dieting History

(Skip to page 15 if you are not purchasing dietitian sessions)

Have you tried to lose weight in the past? YES or NO

How many times?_____ Age of first attempt:_____

What did you do?_____

Why did you go on that diet?_____

_____

Have you ever used any of the following for weight control? If yes, please explain.

Commercial diet programs YES___ NO___ _____
Liquid diets YES___ NO___ _____
Fad diets YES___ NO___ _____
Prescription diet pills YES___ NO___ _____
Over-the-counter diet pills YES___ NO___ _____
Laxatives YES___ NO___ _____
Diuretics YES___ NO___ _____
Ipecac Syrup YES___ NO___ _____
Vomiting YES___ NO___ _____
Self-designed programs YES___ NO___ _____
Other_____

Do you experience periods during which you eat uncontrollably? YES or NO
If yes, how often?_____
At what age did you begin?_____

Is this followed by:

____ Vomiting Age began:_____ How often?_____
____ Laxative use Age began:_____ How often?_____
____ Excessive exercising Age began:_____ How often?_____
____ Negative emotions Age began:_____ How often?_____
____ Other_____

Have you ever been diagnosed with an eating disorder? YES or NO
If yes, please explain:_____

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Are you currently or have you ever received treatment? YES or NO
If yes, please explain:_____

Do you currently exercise for weight control? YES or NO
If yes, please explain:_____

Family Weight History:

Are any members of your family overweight? YES or NO
If yes, please explain:_____

Are any members of your family underweight? YES or NO
If yes, please explain:_____

Does anyone in your family diet? YES or NO
If yes, please explain:_____

Did/Does anyone in your family have an eating disorder? YES or NO
If yes, please explain:_____

Does your family eat meals together? YES or NO
If yes, what's a normal meal like?_____

Eating Habits:

Do you skip meals? YES or NO

How many days per week do you eat:
Breakfast:_____ Lunch:_____ Dinner:_____

Do you snack? YES or NO
If yes, when and what does that consist of?_____

Do you buy or pack your lunches?
Buy_____ Number of Days per Week:_____
Pack_____ Number of Days per Week:_____

Do you eat out? YES or NO
If yes, how many meals per week do you eat out?_____
What restaurants do you usually choose?_____

Who usually prepares the food at home?_____

Do you know how to cook? YES or NO

Who does the grocery shopping?_____

Do you read food labels? YES or NO

If yes, what do you look for on the labels?_____

Do nutrition facts influence your decisions to eat certain foods?	YES or NO
Do you eat standing up?	YES or NO
Do you eat while watching TV?	YES or NO
Do you eat while reading or on the computer?	YES or NO
Do you eat with others?	YES or NO
Do you eat fast?	YES or NO
Do you eat when bored?	YES or NO
Do you eat when stressed?	YES or NO
Do you eat when anxious?	YES or NO
Do you eat when lonely?	YES or NO
Do you eat when hungry?	YES or NO
Do you eat when not hungry?	YES or NO
Do you avoid certain foods?	YES or NO

If yes, please specify:_____

What are your favorite foods?_____

Goals/Expectations

Do you want to change your eating habits? YES or NO

Why?_____

_____

List three goals (short term 1-4 weeks, long term 3-6 months, ultimate goal)

1. _____
2. _____
3. _____

What lifestyle habits are you looking to improve?

_____

_____

_____

West River Community Center

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Food Frequency Checklist

Check the frequency the following foods are consumed	Never or less than once per week	1-2 times per week	3-7 times per week	More than once per day
Beef				
Sausage, Bacon, Lunchmeat				
Pork				
Poultry				
Breaded Poultry (i.e. nuggets)				
Fried Poultry				
Fish				
Breaded Fish (i.e. fish sticks)				
Fried Fish				
Shellfish				
Beans				
Peanut Butter				
Pizza				
Milk (which %)				
Cream				
Cheese				
Regular Cheese				
Low Fat Cheese				
Non-Fat Cheese				
Yogurt				
Ice Cream				
Frozen Yogurt				
Eggs				
Oils				
Butter				
Margarine				
Vegetables				
Fruits				
Fruit Juice				
Breads				
Cereals				
Pasta, noodles, rice, etc. (cup)				
Potatoes				
Commercial baked goods (cookies, donuts, cakes, etc.) (serving)				
Cookies				
Soft Drinks (non-diet) (serving)				
Snack crackers (serving)				
Nuts and Seeds (1/4 cup)				
Potato Chips or Corn Chips (cup)				
Sherberts and Ices (1/2 cup)				
Candy				
Frozen Meals				
Chinese Food				
Fast Food				

Food Likes & Dislikes

Food	Likes	Dislikes
Vegetables	*i.e. cauliflower*	*i.e. broccoli*
Fruits		
Pasta, Rice (egg noodles, macaroni, etc)		
Poultry (chicken, turkey, etc)		
Beef (steaks, hamburger, etc)		
Dairy Cheese (cheese, eggs, milk, etc)		

Daily Food and Exercise Log

What time do you typically wake up?_____

Time of Day	Amount of Food	Type of Food or Beverage	How was it prepared?	How did you feel after you ate or drank? (Examples: Full, Bloated, Tired, Satisfied)

Exercise

Time	Duration	Description

Personal Trainer and Client Code of Conduct

The Personal Trainer will adhere to the following:

1. Personal Trainers shall be committed to providing information that is consistent with both the requirements and the limitations of their profession.

2. Personal Trainers shall preserve the confidentiality of privileged information and shall not release such information to a third party unless the client consents to such release or release is permitted or required by law.

3. Personal Trainers and clients shall comply with applicable local, state, and federal laws and with the West River Community Center policies, procedures and guidelines.

4. Personal Trainers shall not misrepresent in any manner, either directly or indirectly, their skills, training, professional credentials, identity, or services.

5. Personal Trainers shall provide only those services for which they are qualified via education and/or experience and by pertinent legal regulatory process.

6. Personal Trainers shall not engage in any form of conduct that constitutes a conflict of interest or that adversely reflects on the profession or on the West River Community Center.

7. Personal Trainers shall never discriminate against any client based in race, creed, national origin, gender, religion, age, handicap/disability, or other such legal classifications.

8. Personal Trainers shall contact new clients within 3 business days of client payment to schedule the first meeting.

9. If a Personal Trainer is late to a scheduled session, the missed time is owed at no charge to the client. If a trainer consistently arrives late, please contact the West River Community Center at (701) 456-2070.

10. Personal Trainers shall contact their client within 24 hours to cancel an appointment. Failure to notify the client within this time period will result in the trainer training the client for free. If a trainer consistently cancels, please contact the West River Community Center at (701) 456-2070.

Personal Trainer and Client Code of Conduct (cont.)

The client will adhere to the following:

1. For personal training services, there is an additional fee for West River Community Center Members. This fee must be prepaid at the front desk of the Community Center and the receipt must be presented to your trainer prior to your first session.

2. All clients must present a valid West River Community Center ID or pay a daily fee to gain entrance to the building.
   Client & Trainer Initial Here: _____

3. If the client is late to a session, the session will last until the end of the hour that was originally agreed upon. For example, if a session was scheduled for 2-3pm, and the client arrives at 2:10pm, the session will still end at 3pm. If a client is more than 15 minutes late to a session, the trainer is not obligated to stay past that time to wait for the client.
   Client & Trainer Initial Here: _____

4. If the client must cancel a session, 24 hours notice is required. If proper notice is not given the trainer will be required to charge for that session.
   Client & Trainer Initial Here: _____

5. If the client does NOT use his/her sessions within six months of the purchase date the sessions will expire and become invalid.
   Client & Trainer Initial Here: _____

6. Refunds will only be given due to lifestyle changes. Sessions purchased cannot be transfered to other individuals.
   Client & Trainer Initial Here: _____

By signing below I acknowledge that I have read and understand the information in the Personal Trainer and Client Code of Conduct.

Client Signature: _____

Trainer Signature: _____

PERSONAL TRAINING CLIENT PACKET

West River Community Center Assumption of Risk, Release, Indemnification and Participation Agreement

"I,_____, have enrolled in the personalized health and fitness program offered through the West River Community Center. I recognize that the program may involve strenuous physical activity including, but not limited to, muscle strength and endurance training, cardiovascular conditioning and training, and other various fitness activities. I hereby affirm that I am in good physical condition and do not suffer from any known disability or condition which would prevent or limit my participation in this exercise program. I acknowledge that my enrollment and subsequent participation in purely voluntary and in no way mandated by the West River Community Center."

"In consideration of my participation in this program, I,_____, hereby release the West River Community Center and its agents from any liability now or in the future for conditions that I may obtain. These conditions may include, but are not limited to, heart attacks, muscle strains, muscle pulls, muscle tears, broken bones, shin splints, heat prostration, injuries to knees, injuries to back, injuries to foot, or any other illness or soreness that I may incur, including death."

My personal trainer will design an exercise program individualized to meet my needs and desired outcomes, however, results cannot be guaranteed and are based solely on my effort and cooperation in and outside of the training sessions.

Client Initial Here: _____

My program will be explained to me. I will be instructed as to the signs and symptoms, which I should report to my physician and/or personal trainer and which will alert me to modify my exercise activities.

Client Initial Here: _____

I HEREBY AFFIRM THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE STATEMENTS. I CONFIRM THAT I AM 18 OR OLDER AND I EXECUTE THIS DOCUMENT WITH FULL KNOWLEDGE OF THE CONTENTS AND CONSEQUENCES STATED IN THIS RELEASE.

Participant Signature

Signature:_____Date:_____

Printed Name:_____Date of Birth:_____

Parent or Guardian Signature (if under 18 years):_____

Emergency Contact Information

Name:_____Relationship:_____

City:_____Day Phone:_____Evening Phone:_____