THE FITNESS CENTER
AT BENTWATER

Personal Training Client Sheet

Member Name:____

Phone Number:____

Cell Phone Number:______________________________________

Email Address:____

Fitness Goals:

____

____

____

____

Trainer Recommendations:

____

____

____

____

Trainer Name:____ Date:_________________

Contact 936-597-2260 to Schedule Personal Training

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PHYSICIAN'S CLEARANCE FORM

____

PATIENT'S NAME & AGE

________ Date of last physical examination

________ The patient may participate fully in a physical activity program consisting of cardiovascular, strength, and flexibility training without limitation.

________ The patient may participate in a physical activity program with the following limitations and/or recommendations.

Please include a brief description of any medical condition that might affect their physical activity program:

If this patient is on medication that may affect the heart rate or the blood pressure response to exercise (elevating or suppressing), please indicate:

I consider the above individual to be:

_________ Normal

_________ Cardiac Patient

_________ Prone to Coronary Heart Disease

_________ Other (explain)

Please provide the following information if available:

_________Blood Pressure

_________Glucose

_________Total Serum

_________Cholesterol

_________HDL-C LDL-C

_________Triglycerides

PHYSICIAN'S SIGNATURE: ______________________________________

DATE: ______________________

Please note: This record must be stamped with a physician's official stamp or be accompanied by a typed letter on a physician's letterhead, documenting that a medical evaluation has been performed on the named client. The Physician's clearance form will not be accepted without such proper verification

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INFORMED CONSENT FORM

INFORMED CONSENT FOR PARTICIPATION IN A HEALTH-RELATED EVALUATION

By signing this document, I acknowledge that I have voluntarily chosen to participate in a program of progressive physical exercise and testing consisting on aerobic exercise and strength training and which may include, among other activities, stretching, walking, running, bicycle riding, swimming, step aerobics, weight training and resistance training (Program). In signing this document, I acknowledge being informed of the strenuous nature of the Program and the potential for possible physiological results including, but not limited to, abnormal blood pressure, shortness of breath, fainting, heart attack, or death. I acknowledge, further, that I have been advised to be examined by a competent, duly licensed, physician of my own choosing and obtain from that physician his or her approval to participate in the Program is completely voluntary. I accept all responsibility for my health and any resultant injury or mishap that may affect my well-being, and with respect to any injuries and damages related to the Program.

THIS IS IN NO WAY A MEDICAL EXAM PERFORMED BY A MEDICAL PRACTITIONER.

I am freely and voluntarily executing this informed consent, and acknowledge that I have read this form and agree to participate in this evaluation.

PROGRAM PARTICIPANT DATE

PARENT OR GUARDIAN (IF UNDER 18) DATE

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MEDICAL HISTORY FORM FOR PERSONAL TRAINING

Name **Date**

Phone# **Email**

HEIGHT **WEIGHT** **DOB / AGE**

EMERGENCY CONTACT **RELATIONSHIP**

PHYSICIAN NAME **PHYSICAN PHONE#**

ARE YOU CURRENTLY UNDER DOCTOR'S CARE?

IF YES, PLEASE EXPLAIN:

DATE OF YOUR LAST PHYSICAL EXAMINATION__________________

HAVE YOU HAD AN EXERCISE STRESS TEST?

IF YES, WERE THE RESULTS NORMAL OR ABNORMAL, PLEASE EXPLAIN:

PLEASE LIST ANY CURRENT MEDICATIONS YOU ARE TAKING:

HAVE YOU RECENTLY BEEN HOSPITALIZED? IF YES, PLEASE EXPLAIN:

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MEDICAL HISTORY FORM, Page 2

PLEASE INDICATE IF YOU HAVE EXPERIENCED THE FOLLOWING:

High Blood Pressure Yes_______ No________

High Cholesterol Yes_______ No________

Diabetes Yes_______ No________

Heart Disease Yes_______ No________

Rheumatic Heart Disease Yes_______ No________

Heart Murmur Yes_______ No________

Chest pain with exertion Yes_______ No________

Irregular beats or palpitations Yes_______ No________

Lightheadedness or fainting Yes_______ No________

Unusual shortness of breath Yes_______ No________

Cramping pains in legs or feet Yes_______ No________

Emphysema Yes_______ No________

Asthma Yes_______ No________

Back Pain: Yes_______ No________ Joint Pain Yes_______ No________

Muscle Pain or an injury Yes_______ No________

Immune disease/disorder Yes_______ No________

PLEASE BRIEFLY EXPLAIN ANY YES ANWERS:

PLEASE INDICATE IF YOU HAVE SIBLINGS WHO, PRIOR TO 55, EXPERIENCED:

Heart Attack or Heart Surgery Yes_______ No________

A Stroke Yes_______ No________

High Blood Pressure Yes_______ No________

High Cholesterol Yes_______ No________

Diabetes Yes_______ No________

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MEDICAL HISTORY FORM, Page 3

PLEASE BRIEFLY EXPLAIN ANY YES ANWERS:

TO THE BEST OF MY KNOWDELDGE, THE ABOVE INFORMATION IS TRUE.

Signature: ____ Date:_______________

Witness: ____ Date:_______________