Personal Training Initial Consultation Packet

Please take a moment to read and fill out this packet to bring to your initial consultation.

Client Name: ___________________________ Email: ___________________________
Phone: ________________________________

Personal Training - Informed Consent

You may be performing a basic Fitness Assessment which includes a sub maximal cycle ergometer test, flexibility test, body composition analysis, and muscle fitness tests. During the cycle ergometer test, you will begin cycling at a fairly low level of intensity, which will be advanced during stages depending on your fitness level. The test may be stopped at any point if you feel any discomfort. It will be normal to feel heavier breathing and some muscle tightness. However, if you feel any dizziness, lightheadedness, nausea, shortness of breath, chest discomfort, or any other discomforts, the test will immediately be stopped. There exists the possibility of certain changes occurring during the test such as: abnormal blood pressure responses, fainting, irregular heart rhythms, and in rare instances, heart attack, stroke, or death. Every effort will be made to minimize these risks by evaluation of preliminary information relating to your health and fitness and by careful observations during testing. Emergency equipment and trained personnel are available to deal with unusual situations that may arise. It is the responsibility of you as the participant to report any information regarding your health status, medical history, all medications, and symptoms that occur with exercise to our staff immediately.

We hope to gain information about your current fitness capacity. This will help establish a personalized exercise program in all fitness components. Any questions about the procedures used during the exercise test or results of your test are encouraged. If you have any concerns or questions, please ask us for further explanations.

In addition, I understand that my trainer may choose to use a third party site called TrainerMetrics to track information and that this information may be accessible. The Website may also contain material that violates the privacy or publicity rights, or infringes the intellectual property and other proprietary rights, of third parties, or the downloading, copying or use of which is subject to additional terms and conditions, stated or unstated. Assess and Progress disclaims any responsibility for any harm resulting from the use by visitors of the Website, or from any downloading by those visitors of content there posted.

I hereby consent to voluntarily engage in an exercise test to determine my exercise capacity. My permission to perform this exercise test is given voluntarily. I understand that I am free to stop the test at any point, if I so desire.

Client Signature: ___________________________ Date: __________
# 2018 PAR-Q+

The Physical Activity Readiness Questionnaire for Everyone

The health benefits of regular physical activity are clear; more people should engage in physical activity every day of the week. Participating in physical activity is very safe for MOST people. This questionnaire will tell you whether it is necessary for you to seek further advice from your doctor OR a qualified exercise professional before becoming more physically active.

## GENERAL HEALTH QUESTIONS

Please read the 7 questions below carefully and answer each one honestly: check YES or NO.

<table>
<thead>
<tr>
<th>Question</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Has your doctor ever said that you have a heart condition OR high blood pressure?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>2) Do you feel pain in your chest at rest, during your daily activities of living, OR when you do physical activity?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>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).</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>4) Have you ever been diagnosed with another chronic medical condition (other than heart disease or high blood pressure)? PLEASE LIST CONDITION(S) HERE:</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>5) Are you currently taking prescribed medications for a chronic medical condition? PLEASE LIST CONDITION(S) AND MEDICATIONS HERE:</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>6) Do you currently have (or have had within the past 12 months) a bone, joint, or soft tissue (muscle, ligament, or tendon) 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) HERE:</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>7) Has your doctor ever said that you should only do medically supervised physical activity?</td>
<td>☐</td>
<td>☐</td>
</tr>
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### If you answered NO to all of the questions above, you are cleared for physical activity.

**Please sign the PARTICIPANT DECLARATION.** You do not need to complete Pages 2 and 3.

- Start becoming much more physically active – start slowly and build up gradually.
- Follow International Physical Activity Guidelines for your age (www.who.int/dietphysicalactivity/en/).
- You may take part in a health and fitness appraisal.
- If you are over the age of 45 yr and NOT accustomed to regular vigorous to maximal effort exercise, consult a qualified exercise professional before engaging in this intensity of exercise.
- If you have any further questions, contact a qualified exercise professional.

### PARTICIPANT DECLARATION

If you are less than the legal age required for consent or require the assent of a care provider, your parent, guardian or care provider must also sign this form.

I, the undersigned, have read, understood to my full satisfaction and completed this questionnaire. I acknowledge that this physical activity clearance is valid for a maximum of 12 months from the date it is completed and becomes invalid if my condition changes. I also acknowledge that the community/fitness centre may retain a copy of this form for records. In these instances, it will maintain the confidentiality of the same, complying with applicable law.

| NAME ___________________________ | DATE ________________ |
| SIGNATURE ______________________ | WITNESS ____________ |

SIGNATURE OF PARENT/GUARDIAN/CARE PROVIDER

### If you answered YES to one or more of the questions above, COMPLETE PAGES 2 AND 3.

**Delay becoming more active if:**

- You have a temporary illness such as a cold or fever; it is best to wait until you feel better.
- You are pregnant - talk to your health care practitioner, your physician, a qualified exercise professional, and/or complete the ePARmed-X at www.eparmedx.com before becoming more physically active.
- Your health changes - answer the questions on Pages 2 and 3 of this document and/or talk to your doctor or a qualified exercise professional before continuing with any physical activity program.
2018 PAR-Q+
FOLLOW-UP QUESTIONS ABOUT YOUR MEDICAL CONDITION(S)

1. Do you have Arthritis, Osteoporosis, or Back Problems?
   If the above condition(s) is/are present, answer questions 1a-1c
   If NO go to question 2
   1a. Do you have difficulty controlling your condition with medications or other physician-prescribed therapies?
      (Answer NO if you are not currently taking medications or other treatments)
      YES □ NO □
   1b. Do you have joint problems causing pain, a recent fracture or fracture caused by osteoporosis or cancer, displaced vertebra (e.g., spondylothesis), and/or spondylosis/pars defect (a crack in the bony ring on the back of the spinal column)?
      YES □ NO □
   1c. Have you had steroid injections or taken steroid tablets regularly for more than 3 months?
      YES □ NO □

2. Do you currently have Cancer of any kind?
   If the above condition(s) is/are present, answer questions 2a-2b
   If NO go to question 3
   2a. Does your cancer diagnosis include any of the following types: lung/bronchogenic, multiple myeloma (cancer of plasma cells), head, and/or neck?
      YES □ NO □
   2b. Are you currently receiving cancer therapy (such as chemotherapy or radiotherapy)?
      YES □ NO □

3. Do you have a Heart or Cardiovascular Condition? This includes Coronary Artery Disease, Heart Failure, Diagnosed Abnormality of Heart Rhythm
   If the above condition(s) is/are present, answer questions 3a-3d
   If NO go to question 4
   3a. Do you have difficulty controlling your condition with medications or other physician-prescribed therapies?
      (Answer NO if you are not currently taking medications or other treatments)
      YES □ NO □
   3b. Do you have an irregular heart beat that requires medical management?
      (e.g., atrial fibrillation, premature ventricular contraction)
      YES □ NO □
   3c. Do you have chronic heart failure?
      YES □ NO □
   3d. Do you have diagnosed coronary artery (cardiovascular) disease and have not participated in regular physical activity in the last 2 months?
      YES □ NO □

4. Do you have High Blood Pressure?
   If the above condition(s) is/are present, answer questions 4a-4b
   If NO go to question 5
   4a. Do you have difficulty controlling your condition with medications or other physician-prescribed therapies?
      (Answer NO if you are not currently taking medications or other treatments)
      YES □ NO □
   4b. Do you have a resting blood pressure equal to or greater than 160/90 mmHg with or without medication?
      (Answer YES if you do not know your resting blood pressure)
      YES □ NO □

5. Do you have any Metabolic Conditions? This includes Type 1 Diabetes, Type 2 Diabetes, Pre-Diabetes
   If the above condition(s) is/are present, answer questions 5a-5e
   If NO go to question 6
   5a. Do you often have difficulty controlling your blood sugar levels with foods, medications, or other physician-prescribed therapies?
      YES □ NO □
   5b. Do you often suffer from signs and symptoms of low blood sugar (hypoglycemia) following exercise and/or during activities of daily living? Signs of hypoglycemia may include shakiness, nervousness, unusual irritability, abnormal sweating, dizziness or light-headedness, mental confusion, difficulty speaking, weakness, or sleepiness.
      YES □ NO □
   5c. Do you have any signs or symptoms of diabetes complications such as heart or vascular disease and/or complications affecting your eyes, kidneys, OR the sensation in your toes and feet?
      YES □ NO □
   5d. Do you have other metabolic conditions (such as current pregnancy-related diabetes, chronic kidney disease, or liver problems)?
      YES □ NO □
   5e. Are you planning to engage in what for you is unusually high (or vigorous) intensity exercise in the near future?
      YES □ NO □
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6. Do you have any Mental Health Problems or Learning Difficulties? This includes Alzheimer’s, Dementia, Depression, Anxiety Disorder, Eating Disorder, Psychotic Disorder, Intellectual Disability, Down Syndrome
   If the above condition(s) is/are present, answer questions 6a-6b, if NO [ ] go to question 7
   6a. Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer NO if you are not currently taking medications or other treatments)

   6b. Do you have Down Syndrome AND back problems affecting nerves or muscles?

7. Do you have a Respiratory Disease? This includes Chronic Obstructive Pulmonary Disease, Asthma, Pulmonary High Blood Pressure
   If the above condition(s) is/are present, answer questions 7a-7d, if NO [ ] go to question 8
   7a. Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer NO if you are not currently taking medications or other treatments)

   7b. Has your doctor ever said your blood oxygen level is low at rest or during exercise and/or that you require supplemental oxygen therapy?

   7c. If asthmatic, do you currently have symptoms of chest tightness, wheezing, laboured breathing, consistent cough (more than 2 days/week), or have you used your rescue medication more than twice in the last week?

   7d. Has your doctor ever said you have high blood pressure in the blood vessels of your lungs?

8. Do you have a Spinal Cord Injury? This includes Tetraplegia and Paraplegia
   If the above condition(s) is/are present, answer questions 8a-8c, if NO [ ] go to question 9
   8a. Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer NO if you are not currently taking medications or other treatments)

   8b. Do you commonly exhibit low resting blood pressure significant enough to cause dizziness, light-headedness, and/or fainting?

   8c. Has your physician indicated that you exhibit sudden bouts of high blood pressure (known as Autonomic Dysreflexia)?

9. Have you had a Stroke? This includes Transient Ischemic Attack (TIA) or Cerebrovascular Event
   If the above condition(s) is/are present, answer questions 9a-9c, if NO [ ] go to question 10
   9a. Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer NO if you are not currently taking medications or other treatments)

   9b. Do you have any impairment in walking or mobility?

   9c. Have you experienced a stroke or impairment in nerves or muscles in the past 6 months?

10. Do you have any other medical condition not listed above or do you have two or more medical conditions?
    If you have other medical conditions, answer questions 10a-10c, if NO [ ] read the Page 4 recommendations
   10a. Have you experienced a blackout, fainted, or lost consciousness as a result of a head injury within the last 12 months OR have you had a diagnosed concussion within the last 12 months?

   10b. Do you have a medical condition that is not listed (such as epilepsy, neurological conditions, kidney problems)?

   10c. Do you currently live with two or more medical conditions?

PLEASE LIST YOUR MEDICAL CONDITION(S) AND ANY RELATED MEDICATIONS HERE: ______________________

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GO to Page 4 for recommendations about your current medical condition(s) and sign the PARTICIPANT DECLARATION.
2018 PAR-Q+

If you answered NO to all of the FOLLOW-UP questions (pgs. 2-3) about your medical condition, you are ready to become more physically active - sign the PARTICIPANT DECLARATION below:

- It is advised that you consult a qualified exercise professional to help you develop a safe and effective physical activity plan to meet your needs.
- You are encouraged to start slowly and build up gradually - 20 to 60 minutes of low to moderate intensity exercise, 3-5 days per week including aerobic and muscle strengthening exercises.
- As you progress, you should aim to accumulate 150 minutes or more of moderate intensity physical activity per week.
- If you are over the age of 45 yr and NOT accustomed to regular vigorous to maximal effort exercise, consult a qualified exercise professional before engaging in this intensity of exercise.

If you answered YES to one or more of the follow-up questions about your medical condition:
You should seek further information before becoming more physically active or engaging in a fitness appraisal. You should complete the specially designed online screening and exercise recommendations program - the ePARmed-X+ at www.eparmedx.com and/or visit a qualified exercise professional to work through the ePARmed-X+ and for further information.

Delay becoming more active if:

- You have a temporary illness such as a cold or fever; it is best to wait until you feel better.
- You are pregnant - talk to your health care practitioner, your physician, a qualified exercise professional, and/or complete the ePARmed-X+ at www.eparmedx.com before becoming more physically active.
- Your health changes - talk to your doctor or qualified exercise professional before continuing with any physical activity program.

- You are encouraged to photocopy the PAR-Q+. You must use the entire questionnaire and NO changes are permitted.
- The authors, the PAR-Q+ Collaboration, partner organizations, and their agents assume no liability for persons who undertake physical activity and/or make use of the PAR-Q+ or ePARmed-X+. If in doubt after completing the questionnaire, consult your doctor prior to physical activity.

PARTICIPANT DECLARATION
- All persons who have completed the PAR-Q+ please read and sign the declaration below.

I, the undersigned, have read, understood to my full satisfaction and completed this questionnaire. I acknowledge that this physical activity clearance is valid for a maximum of 12 months from the date it is completed and becomes invalid if my condition changes. I also acknowledge that the community/facility center may retain a copy of this form for records. In these instances, it will maintain the confidentiality of the same, complying with applicable law.

NAME ___________________________ DATE ___________________________

SIGNATURE ___________________________ WITNESS ___________________________

SIGNATURE OF PARENT/GUARDIAN/CARE PROVIDER

For more information, please contact
www.eparmedx.com
Email: eparmedx@gmail.com

The PAR-Q+ was created using the evidence-based AGREE process (1) by the PAR-Q+ Collaboration chaired by Dr. Darren E. A. Warren with Dr. Norman Gledhill, Dr. Veronica Jarvik, and Dr. Donald C. McKenney (2). Production of this document has been made possible through financial contributions from the Public Health Agency of Canada and the BC Ministry of Health Services. The views expressed herein do not necessarily represent the views of the Public Health Agency of Canada or the BC Ministry of Health Services.

Key References

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01-11-2017
Health History Questionnaire

Name _______________________________________________ Date ____________________________

Age_____________ Sex □ M  □ F

Physician’s Name ____________________________________________ Physician’s Phone (_________) ______________________

Person to contact in case of emergency:
Name ____________________________________________ Phone _________________________

Are you taking any medications, supplements, or drugs? If so, please list medication, dose, and reason.
_________________________________________________________________________________________
_________________________________________________________________________________________
_________________________________________________________________________________________

Does your physician know you are participating in this exercise program?
_________________________________________________________________________________________

Describe any physical activity you do somewhat regularly.
_________________________________________________________________________________________

Do you now have, or have you had in the past:
1. History of heart problems, chest pain, or stroke □ Yes □ No
2. Elevated blood pressure □ Yes □ No
3. Any chronic illness or condition □ Yes □ No
4. Difficulty with physical exercise □ Yes □ No
5. Advice from physician not to exercise □ Yes □ No
6. Recent surgery (last 12 months) □ Yes □ No
7. Pregnancy (now or within last 3 months) □ Yes □ No
8. History of breathing or lung problems □ Yes □ No
9. Muscle, joint, or back disorder, or any previous injury still affecting you □ Yes □ No
10. Diabetes or metabolic syndrome □ Yes □ No
11. Thyroid condition □ Yes □ No
12. Cigarette smoking habit □ Yes □ No
13. Obesity [body mass index (BMI) ≥30 kg/m²] □ Yes □ No
14. Elevated blood cholesterol □ Yes □ No
15. History of heart problems in immediate family □ Yes □ No
16. Hernia, or any condition that may be aggravated by lifting weights or other physical activity □ Yes □ No

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Interests and Goals

Please check any of the following activities that you enjoy doing or would be interested in trying:

- Baseball
- Basketball
- Boxing/Kickboxing/Martial Arts
- Cardio machines
- CrossFit/HIIT/Insanity/Boot Camp
- Dancing
- Fitness Classes
- Football
- Golf
- Group training
- Hiking
- Olympic Lifting
- Outdoor Activities
- Partner training
- Pilates
- Power Lifting
- Running/Jogging
- Soccer
- Sports in general
- Swimming
- TRX/Suspension Training
- Volleyball
- Walking
- Weight Lifting
- Yoga
- Other: ____________________________

Goal setting is important when designing and monitoring an exercise program. Setting specific, measurable, attainable, relevant, timely goals will be something you and your trainer do together to assure that you get the most out of each session.

**Specific** - Try making your goal specific by stating exactly what you wish to change.

**Measurable** - How will you be able to measure your accomplishments? How much weight? How many reps?

**Attainable** - Make sure your goals are challenging, but possible in the amount of time you wish to accomplish your goals.

**Relevant** - Are your goals pertinent to your interests, needs, and abilities?

**Timely** - Set a timeline to reach your goals.

Please write out 3 fitness goals. This will help the trainer understand your fitness interests.

1. __________________________________________________________________________
   __________________________________________________________________________
   __________________________________________________________________________

2. __________________________________________________________________________
   __________________________________________________________________________
   __________________________________________________________________________

3. __________________________________________________________________________
   __________________________________________________________________________
   __________________________________________________________________________