



Foothills

Park & Recreation District

Personal Training • Sport Performance • Private Training

New Client Packet

Personal Training Options:

- Personal Training - general health, fitness, strength & endurance training with a certified Personal Trainer.
- Sport Performance – athletic-based and sport-specific training with a certified Strength & Conditioning/Performance Enhancement Specialist.
- Specialty Private Training – individualized programming with a Pilates Reformer or Yoga Specialty Instructor.

Thank you for choosing our personal training, sport performance or private mind-body training services at Foothills for all ages. Our goal is to customize a fitness program to fit your unique needs. Sessions will include consultation, assessment and training time to ensure your program is appropriate for your goals.

Please take a few moments to **complete the Health History Questionnaire, PAR-Q+, Cancellation Policy and Release** forms. *Note: you will need the Physician's Consent form prior to any testing or training if you have two or more chronic conditions or answer yes to any of the PAR-Q+ follow-up questions about your medical condition.*

Thank you for taking the time to complete this important information.

If you have questions, please call (303) 409-2263.

~Foothills Fitness & Wellness

HEALTH HISTORY QUESTIONNAIRE

Physician Consent is needed prior to participation in Personal or Private Training or Fitness Assessments if you:

- Have two or more chronic conditions or answered yes to PAR-Q medical follow-up questions
- Have any conditions prohibitive to fitness testing or exercise

P Participant Name _____ Date _____
E Address _____
R City _____ State _____ Zip _____
S Home Phone _____ Work Phone _____ E-mail _____
O Date of Birth _____ Sex _____ Weight _____ Height _____
N
A
L

PAST HISTORY

Check if you've had . . .

___ heart murmur
 ___ high blood pressure
 ___ disease of arteries
 ___ high cholesterol
 ___ heart attack
 ___ chest pain
 ___ stroke
 ___ cancer
 ___ lung disease
 ___ epilepsy
 ___ diabetes mellitus
 ___ operations
 ___ varicose veins
 ___ injuries to back, knees, ankles
 ___ other

FAMILY HISTORY

*Including parents, grand
 parents, siblings*

___ heart attacks
 ___ high blood pressure
 ___ heart operations
 ___ congenital heart disease
 ___ cancer
 ___ diabetes mellitus
 ___ other major illnesses

PRESENT SYMPTOMS

Do you experience . . .

___ chest pains
 ___ heart palpitations
 ___ cancer
 ___ shortness of breath
 ___ back pain
 ___ arthritis
 ___ swollen legs
 ___ injuries
 ___ osteoporosis
 ___ high blood pressure

Explain each item checked: _____

PRESENT MEDICATIONS:

In case of emergency, please contact:

Name _____ Phone _____

Participant Signature _____
 (parent/legal guardian if under 18)







2023 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.	YES	NO
1) Has your doctor ever said that you have a heart condition <input type="checkbox"/> OR high blood pressure <input type="checkbox"/> ?	<input type="checkbox"/>	<input type="checkbox"/>
2) Do you feel pain in your chest at rest, during your daily activities of living, OR when you do physical activity?	<input type="checkbox"/>	<input type="checkbox"/>
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).	<input type="checkbox"/>	<input type="checkbox"/>
4) Have you ever been diagnosed with another chronic medical condition (other than heart disease or high blood pressure)? PLEASE LIST CONDITION(S) HERE: _____	<input type="checkbox"/>	<input type="checkbox"/>
5) Are you currently taking prescribed medications for a chronic medical condition? PLEASE LIST CONDITION(S) AND MEDICATIONS HERE: _____	<input type="checkbox"/>	<input type="checkbox"/>
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: _____	<input type="checkbox"/>	<input type="checkbox"/>
7) Has your doctor ever said that you should only do medically supervised physical activity?	<input type="checkbox"/>	<input type="checkbox"/>

-  **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 Global Physical Activity Guidelines for your age (<https://www.who.int/publications/i/item/9789240015128>).
 -  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 center may retain a copy of this form for its 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.

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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 <input type="checkbox"/> NO <input type="checkbox"/> |
| 1b. | Do you have joint problems causing pain, a recent fracture or fracture caused by osteoporosis or cancer, displaced vertebra (e.g., spondylolisthesis), and/or spondylolysis/pars defect (a crack in the bony ring on the back of the spinal column)? | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 1c. | Have you had steroid injections or taken steroid tablets regularly for more than 3 months? | YES <input type="checkbox"/> NO <input type="checkbox"/> |

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 <input type="checkbox"/> NO <input type="checkbox"/> |
| 2b. | Are you currently receiving cancer therapy (such as chemotherapy or radiotherapy)? | YES <input type="checkbox"/> NO <input type="checkbox"/> |

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 <input type="checkbox"/> NO <input type="checkbox"/> |
| 3b. | Do you have an irregular heart beat that requires medical management? (e.g., atrial fibrillation, premature ventricular contraction) | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 3c. | Do you have chronic heart failure? | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 3d. | Do you have diagnosed coronary artery (cardiovascular) disease and have not participated in regular physical activity in the last 2 months? | YES <input type="checkbox"/> NO <input type="checkbox"/> |

4. Do you currently 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 <input type="checkbox"/> NO <input type="checkbox"/> |
| 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 <input type="checkbox"/> NO <input type="checkbox"/> |

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 <input type="checkbox"/> NO <input type="checkbox"/> |
| 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 <input type="checkbox"/> NO <input type="checkbox"/> |
| 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 <input type="checkbox"/> NO <input type="checkbox"/> |
| 5d. | Do you have other metabolic conditions (such as current pregnancy-related diabetes, chronic kidney disease, or liver problems)? | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 5e. | Are you planning to engage in what for you is unusually high (or vigorous) intensity exercise in the near future? | YES <input type="checkbox"/> NO <input type="checkbox"/> |

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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) YES ☐ NO ☐

6b. Do you have Down Syndrome **AND** back problems affecting nerves or muscles? YES ☐ NO ☐

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) YES ☐ NO ☐

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? YES ☐ NO ☐

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? YES ☐ NO ☐

7d. Has your doctor ever said you have high blood pressure in the blood vessels of your lungs? YES ☐ NO ☐

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) YES ☐ NO ☐

8b. Do you commonly exhibit low resting blood pressure significant enough to cause dizziness, light-headedness, and/or fainting? YES ☐ NO ☐

8c. Has your physician indicated that you exhibit sudden bouts of high blood pressure (known as Autonomic Dysreflexia)? YES ☐ NO ☐

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) YES ☐ NO ☐

9b. Do you have any impairment in walking or mobility? YES ☐ NO ☐

9c. Have you experienced a stroke or impairment in nerves or muscles in the past 6 months? YES ☐ NO ☐

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? YES ☐ NO ☐

10b. Do you have a medical condition that is not listed (such as epilepsy, neurological conditions, kidney problems)? YES ☐ NO ☐





10c. Do you currently live with two or more medical conditions? YES ☐ NO ☐

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

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

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 **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 health 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.
- 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 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

Citation for PAR-Q+

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Key References

1. Jamnik VK, Warburton DER, Makarski J, McKenzie DC, Shephard RJ, Stone J, and Gledhill N. Enhancing the effectiveness of clearance for physical activity participation; background and overall process. APNM 36(S1):S3-S13, 2011.
2. Warburton DER, Gledhill N, Jamnik VK, Bredin SSD, McKenzie DC, Stone J, Charlesworth S, and Shephard RJ. Evidence-based risk assessment and recommendations for physical activity clearance; Consensus Document. APNM 36(S1):S266-S298, 2011.
3. Chisholm DM, Collis ML, Kulak LL, Davenport W, and Gruber N. Physical activity readiness. British Columbia Medical Journal. 1975;17:375-378.
4. Thomas S, Reading J, and Shephard RJ. Revision of the Physical Activity Readiness Questionnaire (PAR-Q). Canadian Journal of Sport Science 1992;17:4 338-345.

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Informed Consent

1. Purpose and Explanation of Exercises & Tests

A variety of exercises and tests (assessments) may be administered to determine the best way to proceed with training based on individual needs and goals. Tests may include resting measures, blood pressure, body composition, strength, power, speed, flexibility, balance, and cardiorespiratory tests. Cardiorespiratory assessments may include step tests, walking or running tests or a graded exercise test performed on a motor driven treadmill with the amount of effort gradually increasing. Tests and exercises are stopped when a certain time, number of repetitions or pre-determined heart rate is reached, at any time due to symptoms such as fatigue, shortness of breath, or chest discomfort, or at the participant's request to stop. All tests/exercises will be explained and participant is instructed to ask questions or stop at any time if they have concerns or symptoms. Testing/exercises will be specific to the mode of training requested and each individual.

2. Risks and discomforts

During exercise training and testing certain changes may occur. These changes or risks include, but are not necessarily limited to, abnormal blood pressure, fainting, disorders of heart rhythm, and very rare instances of heart attack or other bodily injury; as well as a variety of other possible occurrences, any one of which could conceivably, however remotely, cause bodily injury, impairment, disability or death. Any testing or exercises such as these carry with it some risk however unlikely or remote. There are also other risks of injury, impairment, disability, disfigurement, and even death. The undersigned acknowledges and agrees to assume all risk.

3. Expected benefits

These tests and exercises allow fitness professionals to assess physical working capacity, strength and fitness compared to the general populations and/or for sports and recreational activities. The results are used to prescribe a safe, sound exercise program and to monitor changes.

Records are kept confidential used only by program staff to evaluate exercise status or needs unless you consent to release of this information.

4. Inquiries

Questions about the procedures used in these tests or exercises are encouraged. Individuals agree to ask for further explanation for any additional questions or needed information.

5. Freedom of consent

Performance of any exercises &/or testing is strictly voluntary at the discretion of you as an individual. Participants are free to deny consent and discontinue training exercises or testing any time if desired.

I, the undersigned, have read this form carefully and fully understand the test and exercise procedures. I consent to participate in this test and exercise training.

Participant Name (printed)

Participant Signature (parent/legal guardian if under 18)

Date

Witness Signature

Date



PERSONAL TRAINING - RELEASE AND INDEMNIFICATION FORM

We strongly recommend that all participants in our personal training program consult their physician prior to participation.

In consideration of the acceptance of my participation in the Foothills Park & Recreation Districts Personal Training Program, I, the undersigned, intending to be legally bound for myself, my heirs, executors, administrators, and assignees, do hereby waive, release, and forever discharge Foothills Park & Recreation District ("District"), its agents, contractors, employees, representatives, successors, and assignees, from all liabilities, actions, claims, demand, damages, costs, and expenses, which I may now or in the future have against them or any of them arising out of or in any way connected with my participation in the program, including but not limited to all injuries that may be suffered by me. I understand that this waiver includes, but is not limited to any claims that are based on negligence or other action or inaction of the above named parties. In further consideration of the acceptance of my entry, the undersigned indemnifies and holds harmless Foothills Park & Recreation District, its officers, directors, agents, and employees against all liabilities, claims, damages, and expenses of every kind and nature which grow out of or are in any way connected with the conduct or organization of this program.

1. I understand and am aware that strength, flexibility, and aerobic exercise, including the use of equipment, are potentially hazardous activities. I also understand that fitness activities involve a risk of injury and even death, and I am voluntarily participating in these activities and using equipment and machinery with knowledge of the dangers involved. I agree to expressly assume and accept any and all risks of injury or death.

2. I do further declare myself to be physically sound and suffering from no condition, impairment, disease, infirmity, or other illness that would prevent my participation or use of equipment and machinery. I do acknowledge that I have been informed of the desirability for a physician's approval for my participation in an exercise/fitness activity or in the use of exercise equipment and machinery. I also acknowledge that it has been recommended that I have a yearly or more frequent physical examination and consultation with my physician as to my physical activity, exercise, and use of exercise and training equipment so I might have his/her recommendations concerning these fitness activities and equipment use. I affirm that I have either had a physical examination and have been given my physician's permission to participate, or that I have decided to participate in activity and use of equipment and machinery without the approval of my physician; and I assume all responsibility for my participation and activities, and utilization of equipment and machinery in my activities.

Participants Name: _____

Parent/Legal Guardian Name: _____
(if under 18 years old)

Signature _____
(parent/legal guardian if under 18 years old)

Date: _____



Personal Trainer/Client Agreement & Cancellation Policy

I understand and agree to the following:

- Willingly inform my personal trainer of health changes, precautions or limitations.
- Notify my personal trainer of any medication changes.
- Give at least 24-hour notice for cancellation of appointments (emergencies will be taken into consideration), otherwise I agree to make a full payment for the session.
- Arrive on time. If I don't show up within 10 minutes of my scheduled start time, it is considered a "no show" and I will be charged full payment. Session will end on time even if I'm late.
- Sessions will consist of any combination of consultation, assessments/testing and training.
- Personal training may require physical contact for safety &/or spotting of some exercises/stretching and in developing body awareness and/or correcting body position or alignment. Personal trainer will inform you as needed.
- Stop participation and communicate any concerns, symptoms (i.e. joint pain, dizziness, etc.) or if something doesn't feel safe.

Client Signature
(parent/legal guardian if under 18)

Date

Personal Trainer Signature

Date