



Personal Training New Client Intake Packet

For questions or additional information call the Fitness Assistant at 303-409-2265 or the Fitness Specialist at 303-409-2263.

Required fields are marked with an asterisk (*).

Client Information

Full Name* : _____ Date of Birth* : _____

Age* : _____ Gender* : _____ Height* : _____ Weight* : _____

Contact Information

Street Address* : _____

City* : _____ State* : _____ Zip Code* : _____

Email* : _____ Phone (cell)* : _____ Phone (other): _____

Emergency Contact Information

Full Name* : _____ Relationship* : _____

Phone (cell)* : _____ Phone (other): _____

Disclaimer

Participating in physical activity has known health benefits and is very safe for most people. Personal health and medical history are used to identify potential risks or limitations that might affect participation. For your safety, Medical Clearance may be required prior to training based on current symptoms, and the Physical Activity Preparticipation Health Screening, as requested by Fitness Staff. If needed, your healthcare provider will give approval, recommendations, restrictions, or limitations as needed. Please answer all questions accurately to ensure the best programming for you.

Training Preferences & Availability

Please select the type of training you are requesting, and all the days and times you are available and prefer. The more flexible your availability is, the easier it will be to match you to a trainer.*

Type of Training Requested

Personal Training (general health, fitness, strength, and endurance)

Sport Performance (athletic-based and sport specific strength and conditioning)

Chronic Conditions (exercise protocols for early stages of Parkinson's disease, dementia, cancer at any stage, and other chronic conditions)

Pilates Reformer

Yoga

Training Days & Times Requested

	Mon	Tue	Wed	Thurs	Fri	Sat	Sun
6am-10am							
10am-2pm							
2pm-6pm							
6pm-8pm							
Flexible							

Exercise History & Goals

Are you currently participating in planned, structured physical activity for at least 30 minutes at moderate intensity on at least 3 days per week, for at least 3 months?^{*} :

Yes No

If you answered “Yes” to the previous question, please provide a description how long and how often:

Select any activities that you are currently involved in:

- | | | |
|----------|-----------------|-----------------------|
| Walking | Cycling | Strength Training |
| Jogging | Cardio Machines | Group Fitness Classes |
| Swimming | Athletic Drills | Other |

If you selected “Other”, please provide a description of your current activities:

Please list any activities that you are interested in* :

Please describe your past and present activities and exercises, please note which ones were the most beneficial* :

Select your top three goals for training services* :

Improve strength

Increase energy

Lose weight

Gain muscle

Improve flexibility

Improve balance

Increase endurance

Reduce stress

Develop accountability

Learn equipment and proper form

Develop an individualized program

Maintain bone health

Develop consistency

Other

If you have selected "Other", please provide a description of your desired goals:

Physical Activity Preparticipation Health Screening

General Health Questions

Please read the questions below carefully and answer each one honestly.

1. Has your doctor ever said that you have a heart condition OR high blood pressure?* :

Yes No

2. Do you feel pain in your chest at rest, during your daily activities of living, OR when you do physical activity?* :

Yes No

3. Do you lose balance because of dizziness OR have you lost consciousness in the last 12 months? **Note: Please answer NO if your dizziness is associated with over-breathing, including during vigorous exercise.* :**

Yes No

If you answered "Yes" to the previous question, please list conditions related to loss of balance and/or consciousness:

4. Have you ever been diagnosed with another chronic medical condition other than heart disease or high blood pressure?* :

Yes No

5. Are you currently taking any prescribed medication for a chronic medical condition?* :

Yes

No

If you answered "Yes" to the previous question, please list conditions and related medications:

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? **Note: Please answer NO if you had a problem in the past, but it does not limit your current ability to be physically active.* :**

Yes

No

If you answered "Yes" to the previous question, please list related conditions:

7. Has your doctor ever said that you should only do medically supervised physical activity?* :

Yes

No

Current Symptoms

Are you currently experiencing any of the symptoms below?* :

Chest pain or discomfort at rest or with exertion.	Yes	No
Unreasonable shortness of breath.	Yes	No
Burning or cramping sensations in your lower legs when walking.	Yes	No
Dizziness, fainting, blackouts.	Yes	No
Unexplained ankle or leg swelling.	Yes	No
Heart palpitations or irregular heart rate.	Yes	No

Current Medications

Please list any medications not previously listed including over-the-counter medications, prescriptions, etc. (If not applicable, write "N/A")* :

Current Allergies

Please list any known allergies. (If not applicable, write "N/A")* :

Known Medical Concerns & Conditions

If not previously listed, please list any known injuries, trouble spots, recent surgeries, or other medical concerns and conditions that might limit your ability to participate in services such as pregnancy, disability, replaced joints, chronic conditions such as heart or lung conditions, metabolic conditions or autoimmune disorders, etc. (If not applicable, write "N/A")* :

Client Signature

I, the undersigned, have read, understood to my satisfaction, and completed this questionnaire fully and honestly. It is recommended I consult with my healthcare provider regarding any possible limitations or guidelines based on my personal health issues. Medical Clearance for Exercise is needed prior to participation if requested by fitness staff and as indicated by the answers provided. I will alert fitness staff if there are any changes in my health conditions, including new medical diagnoses, injuries, or hospitalizations and will resubmit forms or obtain new medical clearance prior to continuing participation upon request. The intake packet will be kept confidential, used only by the designated fitness staff for proper exercise programming.

Full Name (printed)* : _____ **Date*** : _____

Parent/Legal Guardian name (if under 18, printed)* : _____

Client (or Parent/Legal Guardian) Signature* : _____

Release & Indemnification Form

We strongly recommend that all participants consult their physician prior to participation.

In consideration of the acceptance of my participation in the Foothills Park & Recreation District's 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.

1. 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.
2. 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.
3. 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 their 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.

Full Name (printed)* : _____ **Date*** : _____

Parent/Legal Guardian name (if under 18, printed)* : _____

Client (or Parent/Legal Guardian) Signature* : _____

Training Service Terms and Conditions

I understand and agree to conform to the following:

- I will inform my trainer/instructor of any injuries, health or medication changes, or limitations and understand new paperwork and medical release may be needed prior to continued training.
- Full payment is due prior to services being received and cannot be accepted by Fitness Staff.
- Packages expire two years after the date of purchase, unless otherwise specified. Commit to be Fit programs expire after twelve weeks. I understand personal training, private reformer or other fitness packages are not eligible for refunds.
- I will give at least 24-hour notice if I need to cancel or the session will be forfeited and charged to my family account. Emergencies will be considered.
- I understand that if I am late the session will end on time based on the scheduled appointment time. If I am more than 15 minutes late, the session may be forfeited and charged to my account.
- I understand that sessions are any combination of consultation, assessment, instruction, and exercise.
- I give consent for physical contact that may be needed for safety including spotting of exercises and contact to check proper positioning, technique and body alignment.
- I will stop participating if I have any questions, concerns, symptoms (i.e., joint pain, dizziness, etc.) or if something doesn't feel safe.

Participation in any athletic sport program or physically related activity, fitness program, training services, exercises or testing may be dangerous and involves risk of injury, discomfort, loss or damage.

The purpose and explanation for all exercises, activities and fitness testing will be given and specific to individual needs. Benefits of training services include ensuring a balanced exercise plan, learning proper form and continual monitoring and adjustments as needed for a safe and effective fitness program.

The participant takes full responsibility for their actions and physical condition, certifies that all health and fitness intake questions have been answered honestly and thoroughly, and agrees to communicate any symptoms, health or medication changes. Participation is strictly voluntary at the discretion of the individual. The participant is free to deny consent and stop training exercises or testing at any time desired. Records are kept confidential unless consent is given to release information.