

S H E P H E R D U N I V E R S I T Y

Wellness Center

PERSONAL TRAINING PACKET

Revised: 8/2021

Shepherd
UNIVERSITY

EXERCISE PREPARTICIPATION HEALTH-SCREENING QUESTIONNAIRE

Name: _____ Age: _____ Birthday: _____
Email: _____ Phone Number: _____

Assess your health needs by marking all *true* statements.

Step 1

SYMPTOMS

Do you experience:

- | | |
|---|---|
| <input type="checkbox"/> chest discomfort with exertion | <input type="checkbox"/> dizziness, fainting, blackouts |
| <input type="checkbox"/> unreasonable breathlessness | <input type="checkbox"/> ankle swelling |
| <input type="checkbox"/> burning or cramping sensations in your lower legs when walking short distances | <input type="checkbox"/> unpleasant awareness of a forceful, rapid, or irregular heart rate |

If you **did** mark any of these statements under the symptoms, **STOP**, and seek medical clearance before engaging in or resuming exercise. You may need to use a facility with a **medically qualified staff**. Please complete the last page of this packet. If you **did not** mark any symptoms, continue to steps 2 and 3.

Step 2

CURRENT ACTIVITY

Have you performed planned, structured physical activity for at least 30 minutes at moderate intensity on at least 3 days per week for at least the past 3 months?

Yes No

Continue to Step 3.

Step 3

MEDICAL CONDITIONS

Have you had or do you currently have:

- | | |
|--|---|
| <input type="checkbox"/> a heart attack | <input type="checkbox"/> heart transplantation |
| <input type="checkbox"/> heart surgery, cardiac catheterization, or coronary angioplasty | <input type="checkbox"/> congenital heart disease |
| <input type="checkbox"/> pacemaker/implantable cardiac defibrillator/rhythm disturbance | <input type="checkbox"/> diabetes |
| <input type="checkbox"/> heart valve disease | <input type="checkbox"/> renal disease |
| <input type="checkbox"/> heart failure | |

Evaluating Steps 2 and 3:

- If you **did not mark any of the statements in Step 3**, medical clearance is not necessary.
- If you marked Step 2 **“yes”** and **marked any of the statements in Step 3**, you may continue to exercise at light to moderate intensity without medical clearance. Medical clearance is recommended before engaging in vigorous exercise.
- If you marked Step 2 **“no”** and **marked any of the statements in Step 3**, medical clearance is recommended. You may need to use a facility with a **medically qualified staff**. Please complete the last page of this packet.

EXERCISE HISTORY FORM

General Instructions: Please fill out this form as completely as possible. If you have any questions, ask a staff member for assistance.

Rate yourself on a scale of 1 to 5 (1 indicating the lowest value, 5 the highest). Circle the number that best applies.

Characterize your present athletic ability. 1 2 3 4 5

When you exercise, how important is competition? 1 2 3 4 5

Characterize your present cardiovascular capacity. 1 2 3 4 5

Characterize your present muscular capacity. 1 2 3 4 5

Characterize your present flexibility capacity. 1 2 3 4 5

1. Do you have any negative feelings towards, or have you had any bad experiences with , physical activity programs? _____ Yes _____ No

If yes, please specify _____

2. Do you have any negative feelings towards, or have you had any bad experiences with fitness testing and evaluation? _____ Yes _____ No

Is yes, please specify _____

3. Do you start exercise programs but then find yourself unable to stick with them?

_____ Yes _____ No

If yes, why? _____ Time _____ Bored Other: _____

4. Are you currently involved in regular cardiovascular exercise? _____ Yes _____ No

If yes, specify the type of exercise(s) _____ Minutes a Day, _____ Day a Week

Rate the perceived exertion of your cardiovascular program:

_____ Light _____ Fairy Light _____ Somewhat Hard _____ Hard

5. Are you currently involved in regular strength training exercise? Yes No

If yes, specify the type of exercise: Machines Free Weights Days/week

6. Have you ever used Free Weights? Yes No **Weight Machines?** Yes No

I prefer to exercise: on Weight Machines with Free Weights Both

7. How long have you been exercising regularly? _____ Months _____ Years

8. What other exercise, sport or recreational activities have you participated in?

In the past 6 months: _____

In the past 5 years: _____

9. What types of exercise programs interest you?

Walking Jogging/Running Stretching Racquet Sports
 Cycling Aerobic Classes Rowing Stationary Bike
 Free Weights Weight Machines Boxing Other (please list)
 Treadmill Swimming Rowing _____

10. What are your fitness goals in order of priority? (e.g. 1 Fat/Weight Loss; 2 Reduce Stress)

Fat/Weight Loss Muscular Strength Muscular Endurance
 Cardiovascular Tone/Firm Muscles Increase Muscle Mass
 Flexibility Reshape Body Reduce Stress
 Improve Disability Reduce Risk Factors Sport Specific

11. How much are you willing to devote to an exercise program?

___ Minutes a Day, ___ Days a Week

12. How many days would you be willing to work with a trainer?

___ Days a Week

Day(s) most convenient are (circle):

Monday Tuesday Wednesday Thursday Friday Saturday Sunday

Please list special considerations (i.e., medicines, medical conditions, injuries, pain with movement, limited range of motion):

CONSENT & RELEASE LIABILITY FORM

1. The exercise sessions you will become involved with will consist of progressive exercise levels that will be determined and regulated by your trainer. The exercise sessions may consist of aerobic and weight training as well as education and instruction. These exercises are designed to place gradually increasing stress on the body to improve its function, although no guarantee can be made. The trainer will provide spotting and cueing to ensure your safety and at anytime where it would require physical touch, he or she will ask for permission. You have the right to refuse and the exercise will be eliminated for safety reasons.

Initial _____

2. I am aware that all activities are offered as recreational or self directed in nature and I have the right and choice to stop activity at any time. I also assume full responsibility during and after my participation for any risk, discomfort or fatigue that I may experience. I understand that exercise and cardiovascular activity and the response of my body to such activity cannot be predicted. I acknowledge my responsibility and obligation to inform my trainer of any pain, discomfort, fatigue or any other symptoms that I may suffer. It is my choice to participate in the training program. I accept assumption of all the risk that may imply as my own.

Initial _____

3. The information made or gathered during the training sessions is treated as confidential.

Initial _____

4. I understand that I may ask questions or request further information about any of the activities, programs, or services offered by my Shepherd University Wellness Center trainer at any time. It is my choice to participate in the programs offered and may withdrawal from participation as I wish.

Initial _____

5. I understand that all personal training sessions must be paid for in advanced and that I must give 24-hours notice prior to canceling a session. I understand that without given 24-hour notice or not showing up may result in being charged for the scheduled session.

Initial _____

6. I understand that all sessions must be used within one (1) year of purchase date and are not transferable.

Initial _____

I have read and consent to the above information and wish to participate in an exercise program with personal trainer from the Shepherd University Wellness Center.

Signature

Date

Trainer

Date

PHYSICAL ACTIVITY READINESS PHYSICIAN REFERRAL FORM

Based on the current review of the health status of _____(name)
I recommend the following course of action:

- The participant should avoid engaging in physical activity at this time.
- The participant should engage in only a medically supervised physical activity/exercise program involving the supervision of a qualified exercise professional (or other appropriately trained health care professional) and overseen by a physician.
- The participant is cleared for intensity and mode appropriate physical activity/exercise training under the supervision of a qualified exercise professional.
- The participant is cleared for intensity and mode appropriate physical activity/exercise training with limited supervision (i.e., unrestricted physical activity).

The following precautions should be taken when prescribing exercise for the aforementioned participant:

- o With the avoidance of: _____

- o With the inclusion of: _____

NAME OF PHYSICIAN: _____

ADDRESS: _____

TELEPHONE: _____

Date of Medical Clearance (mm/dd/yy): _____

**Please email completed form to
the Shepherd University
Wellness Center:
jnls01@shepherd.edu.**

PHYSICIAN/CLINIC STAMP AND SIGNATURE

NOTE: This physical activity/exercise clearance is valid for a period of six months from the date it is completed and becomes invalid if the medical condition of the above named participant changes/worsens.