SHEPHERD UNIVERSITY

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:

- ☐ chest discomfort with exertion
- ☐ unreasonable breathlessness
- ☐ burning or cramping sensations in your lower legs when walking short distances
- ☐ dizziness, fainting, blackouts
- ☐ ankle swelling
- ☐ 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:

- ☐ a heart attack
- ☐ heart surgery, cardiac catheterization, or coronary angioplasty
- ☐ pacemaker/implantable cardiac defibrillator/rhythm disturbance
- ☐ heart valve disease
- ☐ heart failure
- ☐ heart transplantation
- ☐ congenital heart disease
- ☐ diabetes
- ☐ renal disease

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.

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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):

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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

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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:

- With the avoidance of: ____
  ____
  ____
  ____

- 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: jflora@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.

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