Personal Training
Client Registration

Thank you for choosing Bob Burger Recreation Center for your personal training needs. We take pride in providing the best service we can in helping you achieve your health and fitness goals. Please take a few minutes to complete this packet. Your answers provide our personal training team with valuable information about YOU and your needs and challenges. Please provide as much detail as possible.

Bob L Burger Personal Training Information

Please read carefully

Personal Training Policies

1. City of Lafayette Personal Training Client Registration Packet must be completed and submitted at the Initial Consultation or the first session.
2. Clients must purchase session(s) before the scheduling session(s) with a trainer.
3. Personal Trainers cannot take session payments. Please pay for sessions at the Recreation Center front desk.
4. Call, text, or email your Trainer if you know that you will be late. The scheduled session will be forfeited if the Trainer is unaware that you will be late and you are later than 15 minutes after the scheduled session start time. If you are late, the session's length will be shortened to end at the originally scheduled time.
5. If necessary, sessions must be rescheduled or canceled 24 hours in advance, or the session will be forfeited. Call your Trainer directly to reschedule your appointment.
6. SilverSneakers discounts do not apply to Personal Training.
7. No refunds will be given on Personal Training sessions after six months from the date of purchase. **Personal Training passes expire six months from the date of purchase**.
8. For the safety of your children, please, no children are allowed in the functional fitness or weight roomarea.

Client Confidentiality

Information will not be released without the individual's permission. If you have any feedback regarding your Trainer or the program, please contact the Fitness Coordinator at 303.661.1478.

PERSONAL INFORMATION

Name: _____ Todays Date: _____

DOB/Age:_____ Gender: ☐ M ☐ F

Height:_____Weight: _____

Current Information

Address:_____ Daytime Phone: _____

City:_____State:_____Zip:_____ Evening Phone: _____

Email: _____ Cell Phone:_____

Emergency Contact Information

Name:_____ Relationship:_____

Daytime Phone: _____ Cell Phone:_____

Training Preferences and Availability *View Trainer Bios*

My preferred Trainer is:_____

Please indicate days and times you are available and prefer to train. Please be specific. The more flexibility you have, the easier it is to match a Trainer).

Monday:_____Tuesday:_____Wednesday:_____Thursday: _____

Friday:_____Saturday:_____Sunday: _____

Please Indicate Your Current Level of Satisfaction with the Following:

	Very Dissatisfied	Dissatisfied	Satisfied	Very Satisfied
General Health & Lifestyle	☐	☐	☐	☐
Physical Activity Level	☐	☐	☐	☐
Stress Level	☐	☐	☐	☐
Blood Pressure & Cholesterol	☐	☐	☐	☐
Nutrition & Eating Habits	☐	☐	☐	☐
Weight & Body Composition	☐	☐	☐	☐
Muscular Strength & Endurance	☐	☐	☐	☐
Balance & Fear of Falling	☐	☐	☐	☐
Activities of Daily Living	☐	☐	☐	☐

What goals would you like to achieve by working with a Trainer?

_____

_____

_____

_____

Medications/Allergies

Please list any medical concerns/conditions that might limit your ability to participate in training sessions (pregnancy, disability, chronic conditions, etc.):

_____

_____

_____

_____

Please list current medications, including over-the-counter medications, prescriptions, etc., that may affect your body's response to exercise.

Name of Medication	*Dosage*	*Reason Taken*
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Exercise History and Attitude

Have you been involved in a regular aerobic exercise routine (moderate, continuous activity for at least 15-20 minutes in duration, at least three days/week)? Yes ☐ No ☐

If yes, for how long and what activities? _____

Are you currently involved in a weight training and conditioning program? Yes ☐ No ☐

Minutes/Day:_____ Days/Week_____

If yes, please summarize your current exercise program (types of exercises, goals, equipment used, etc.):

_____

_____

Check (✓) the activities that you would enjoy doing:

☐ Walking ☐ Group Fitness Classes ☐ Strength Training ☐ Athletic Drills

☐ Swimming ☐ Cardio Machines ☐ Rowing ☐ Jogging

☐ Cycling

What other activities are you interested in? _____

How much time are you planning on devoting to a fitness regimen?

On your own time:

Minutes/Day:_____ Days/Week_____

Working with a Trainer:

Days/Week:_____

Waiver of Liability and Release

RECREATION PROGRAM RELEASE

In consideration of my participation and or that of my child or ward in the City of Lafayette ("City") Recreation Department's programs or activities, do hereby for all, to the extent permitted by law assume the risk of participation and waive and release the City, its officers and employees from any and all claims, actions, or demands for any injury, loss, or damage arising out of, or related to participation in the programs or activities, whether or not such is caused by the act, error, omission, negligence or fault of the City, its officers or employees. I also on behalf of myself and my child or ward consent to the City's publication of photographs taken of any of us during our participation in the Recreation Department's programs or activities.

Participant Signature:_____Date:_____
(or Parent/Guardian Signature if participant is a minor)

Terms and Conditions

I agree to adhere to all City of Lafayette Recreation Center's training policies and procedures:
Please initial.

_____I certify that I have answered all health and fitness questions honestly and to the best of my ability.

_____I understand that I may be asked to provide a medical clearance from my doctor before participating in any City of Lafayette Recreation personal training for my safety.

_____All members agree to abide by the Recreation Department facility rules and regulations while in the facility. These rules and regulations may change. Failure to comply with the center's rules and regulations may resultin termination of membership.

_____Patrons wishing to use the facility before or after a scheduled session must pay the daily admission or use their membership card.

_____I must check-in at the front desk for each session and confirm the scheduled session.

_____Session(s) must be purchased before they can be scheduled with the Trainer.

_____Full payment is due before services are received. Trainers cannot accept payment.

_____If I need to cancel my session, I must call my Trainer at least 24 hours before my scheduled session. If I do not call 24 hours prior, that session will be forfeited.

_____If I am late, the session will only last until the end of the hour for which that session was scheduled. If I am more than 15 minutes late, the scheduled session will be forfeited.

_____If my health status changes after completing the registration packet, I will inform my Trainer immediately. I understand that I may need to obtain a physician's clearance before continuing training sessions.

_____**All sessions must be completed within six months of the original purchase date**.

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 ☐ **OR** high blood pressure ☐?	◯	☐
2) Do you feel pain in your chest at rest, during your daily activities of living, **OR** when you do physical activity?	☐	☐
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).	☐	☐
4) Have you ever been diagnosed with another chronic medical condition (other than heart disease or high blood pressure)? **PLEASE LIST CONDITION(S) HERE:** _____	☐	☐
5) Are you currently taking prescribed medications for a chronic medical condition? **PLEASE LIST CONDITION(S) AND MEDICATIONS HERE:** _____	☐	☐
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:** _____	☐	☐
7) Has your doctor ever said that you should only do medically supervised physical activity?	☐	☐

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 the next 2 pages.

- 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 THE NEXT 2 PAGES.

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 the next 2 pages of this document and/or talk to your doctor or a qualified exercise professional before continuing with any physical activity program.

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., spondylolisthesis), and/or spondylolysis/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 chemotheraphy 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 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** ☐ **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** ☐

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 NEXT PAGE for recommendations about your current medical condition(s) and sign the PARTICIPANT DECLARATION.

If you answered NO to all of the FOLLOW-UP questions 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 _____