



For office use only:

Receipt #: _____
Pkg. Purchased: _____
Purchase Date: _____
Expiration Date: _____
Initials: _____

Wildcat Personal Training Fitness Services Medical & Fitness History Form

Participant MUST print clearly

PERSONAL INFORMATION:

Name: _____ Male _____ Female _____

Date of Birth: _____ Spouse's Name (if applicable): _____

Address: _____ City: _____ State: _____ Zip: _____

Day Phone: () _____ Evening Phone: () _____ Cell Phone: () _____

Email Address: _____ How frequently do you check email? _____

Emergency Contact: _____ Relationship: _____

Day Phone: () _____ Evening Phone: () _____

* The **BEST** way to contact you is: _____

Current Status: (Please check ONE)

Student _____ Faculty/Staff _____ Alumni _____ Retiree _____ MCC/AIB/MATC _____

Student Spouse _____ F/S Spouse _____

How did you learn about the Personal Training program?

Rec Services handout _____ Rec Services website _____ Rec Services bulletin board _____ Newspaper article _____

Friend _____ Other (please explain) _____

Scheduling:

Days/Times available to train: _____

Is there a specific trainer that you prefer? _____

Trainer Preference:

Male _____ Female _____ No Preference _____

MEDICAL INFORMATION:

Please indicate whether you currently have or if you ever had a significant problem with any of the symptoms or conditions listed below:

- 1. Has your doctor ever said that you have a heart condition and that you should only do physical activity recommended by a doctor? Yes _____ No _____
- 2. Do you feel pain in your chest when you do physical activity? Yes _____ No _____
- 3. In the past month, have you had chest pain when you were not doing physical activity? Yes _____ No _____
- 4. Do you lose your balance because of dizziness or do you ever lose consciousness? Yes _____ No _____
- 5. Do you have a bone or joint problem (for example, back, knee or hip) that could be made worse by a change in your physical activity? Yes _____ No _____
- 6. Is your doctor currently prescribing drugs (for example, water pills) for your blood pressure or heart condition? Yes _____ No _____
- 7. Do you know of any other reason why you should not do physical activity? Yes _____ No _____

***NOTE: If you answered "yes" to one or more questions above, please speak with your doctor by phone or in person BEFORE you become more physically active or BEFORE you begin personal training and fitness testing. Please tell your doctor which questions you answered "yes" to and discuss possible exercise restrictions. Your safety when becoming more physically active is our main concern. IF YOU ARE PREGNANT OR YOUR HEALTH CHANGES PRIOR TO EXERCISING SO THAT YOU ANSWER "YES" TO ANY OF THE ABOVE QUESTIONS, YOU MUST SPEAK WITH YOUR DOCTOR BEFORE MEETING WITH A PERSONAL TRAINER!**

Condition	Yes	No	Not Sure	Comments
Unexplained weight loss or gain				
Chronic fatigue				
Change in appetite				
Cancer				
Heart attack				
Rapid or irregular heart beats				
High blood pressure				
Stroke				
High blood cholesterol				
High blood triglycerides				
Diabetes				
Hypoglycemia/low blood sugar				
Asthma				
Unexplained shortness of breath during exercise				
Chronic joint or muscle pain				
Back pain				
Arthritis or rheumatic condition				
Bone, joint, or muscular injury				
Surgical procedures				
Thyroid disease				
Epilepsy				
Eating disorder				
Persistent headache				
Bursitis				
Other _____				

***NOTE: Answering "yes" to 3 or more of the above conditions will require a medical clearance for exercise from your doctor. The clearance can be faxed to Recreational Services: 785-532-4983, or delivered to the Recreation Complex administrative office with this completed form.**

Please explain the reason for your last doctor's visit (provide a date if you can remember). _____

Please list any additional medical concerns/conditions that might limit your ability to participate in this program (pregnancy, disability, etc.): _____

Please list any known allergies (environmental, medications, food, etc.): _____

Please list current medications including over-the-counter medications, prescriptions, etc.:

<i>Medication</i>	<i>Dosage</i>	<i>For what?</i>

FAMILY MEDICAL HISTORY:

Please indicate if any family member has had any of the following:

<i>Medical Condition</i>	<i>Relationship</i>	<i>Comments</i>
Heart attack		
Stroke		
Cardiovascular disease		
High blood pressure		
High cholesterol		
Diabetes		
Obesity		
Cancer		
Osteoporosis		
Other		

PERSONAL HABITS:

Do you take a vitamin supplement on a regular basis?
Yes _____ No _____

Are you currently on a special diet or dietary restriction?
Yes _____ No _____

Do you consider yourself overweight?
Yes _____ No _____

Do you consider yourself underweight?
Yes _____ No _____

Do you currently use tobacco products?
Yes _____ No _____

EXERCISE:

Aerobic Activity

Have you been involved in a routine of regular aerobic exercise (moderate, continuous activity for at least 15-20 minutes duration, at least 3 days per week)?

Yes _____ No _____

If yes, for how long? _____

If no, when was the last time you can recall being active for at least 20 minutes? What activity were you doing?

Check the activities below that you would consider doing.

Group Fitness Classes _____ Walking _____ Jogging _____ Cardio Machines _____
 Water Exercise _____ Cycling _____ Swimming _____ Other _____

Training and Conditioning

Are you currently involved in a weight training and conditioning program?

Minutes/day _____ Days/week _____

If yes, please explain your current program: _____

CURRENT LEVELS OF SATISFACTION:

	Generally Satisfied	Generally Dissatisfied	Intend to Make Changes
Weight			
Body composition			
Physical activity level			
Use of tobacco products			
Blood pressure			
Stress level			
Family life			
General health & lifestyle			
Nutrition			
Cholesterol level			

*Please circle, on a scale of 1-10, how willing you are to make lifestyle changes that take commitment (1=very ready; 10= no desire)

1 2 3 4 5 6 7 8 9 10

Current Height _____

Current Weight _____

Before I meet with a Wildcat Personal Trainer, take part in fitness testing, or engage in a training program, I certify that I have answered all health and fitness questions honestly and to the best of my ability. I understand the importance of providing complete and accurate responses. I recognize that my failure to do so could lead to possible unnecessary injury to myself during fitness testing and/or exercise programs. I verify that I have contacted/will contact my doctor prior to becoming more physically active; as stated as a result of my health questions/condition responses, and will provide/have provided a medical clearance from my doctor if necessary.

I understand these services are non-refundable, non-transferable, and expire 6 months from date of purchase.

I also understand my information will be kept in the trainer's possession from time to time to allow them to personalize my workout sessions. After sessions are completed my file will be filed in the Personal Trainer's Room here at the Rec Complex.

Print Name _____ Date _____

Signature _____

