Name_____

Date_____

INFORMED CONSENT FOR PARTICIPATION

IN A HEALTH AND FITNESS TRAINING PROGRAM

NAME: _____ _____ DATE: _____

PURPOSE AND EXPLANATION OF PROCEDURE

I hereby consent to voluntarily engage in an acceptable plan of personal fitness training. I also give consent to be placed in personal fitness training program activities which are recommended to me for improvement of dietary counseling, stress management, and health/fitness education activities. The levels of exercise I perform will be based upon my cardiorespiratory (heart and lungs) and muscular fitness. I understand that I may be required to undergo a graded exercise test prior to the start of my personal fitness training program in order to evaluate and assess my present level of fitness.

I will be given exact personal instructions regarding the amount and kind of exercise I should do. A professionally trained personal fitness trainer will provide leadership to direct my activities, monitor my performance, and otherwise evaluate my effort. Depending upon my health status, I may or may not be required to have my blood pressure and heart rate evaluated during these sessions to regulate my exercise within desired limits. I understand that I am expected to attend every session and to follow staff instructions with regard to exercise, stress management, and other health and fitness regarded programs. If I am taking prescribed medications, I have already so informed the program staff and further agree to so inform them promptly of any changes which my doctor or I have made with regard to use of these. I will be given the opportunity for periodic assessment and evaluation at regular intervals after the start of the program.

I have been informed that during my participation in the above described personal fitness training program, I will be asked to complete the physical activities unless symptoms such as fatigue, shortness of breath, chest discomfort or similar occurrences appear. At this point, I have been advised that it is my complete right to decrease or stop exercise and that it is my obligation to inform the personal fitness training program personnel of my symptoms, should any develop.

I understand that during the performance of exercise, a personal fitness trainer will periodically monitor my performance and, perhaps measuring my pulse, blood pressure, or assess my feelings of effort for the purposes of monitoring my progress. I also understand that the personal fitness trainer may reduce or stop my exercise program when any of these findings so indicate that this should be done for my safety and benefit.

I also understand that during the performance of my personal fitness training program physical touching and positioning of my body may be necessary to assess my muscular and bodily reactions to specific exercises, as well as to ensure that I am using proper technique and body alignment. I expressly consent to the physical contact for the stated reasons above.

RISKS

It is my understanding and I have been informed that there exists the remote possibility during exercise of adverse changes including, but not limited to, abnormal blood pressure, fainting, dizziness, disorders of heart rhythm, and in very rare instances heart attack, stroke, or even death. I further understand and I have been informed that there exists the risk of bodily injury including, but not limited to, injuries to the muscles, ligaments, tendons, and joints of the body. Every effort, I have been told, will be made to minimize these occurrences by proper staff assessments of my condition before each personal fitness training session, staff supervision during exercise and by my own careful control of exercise efforts. I fully understand the risks associated with exercise, including the risk of bodily injury, heart attack, stroke or even death, but knowing these risks, it is my desire to participate as herein indicated.

3. BENEFITS TO BE EXPECTED AND ALTERNATIVES AVAILABLE TO EXERCISE

I understand that this program may or may not benefit my physical fitness or general health. I recognize that involvement in the personal fitness training sessions will allow me to learn proper ways to perform conditioning exercises, use fitness equipment and regulate physical effort. These experiences should benefit me by indicating how my physical limitations may affect my ability to perform various physical activities. I further understand that if I closely follow the program instructions, that I will likely improve my exercise capacity and fitness level after a period of 3-6 months.

4. CONFIDENTIALITY AND USE OF INFORMATION

I have been informed that the information which is obtained in this personal fitness training program will be treated as privileged and confidential and will consequently not be released or revealed to any person, to the use of any information which is not personally identifiable with me for research and statistical purposes so long as same does not identify my person or provide

facts which could lead to my identification. Any other information obtained, however, will be used only by the program staff to evaluate my exercise status or needs.

5. <u>INQUIRIES AND FREEDOM OF CONSENT</u>

I have been given an opportunity to ask questions as to the procedures.

I have read this Informed Consent form, fully understand its terms, understand that I have given up substantial rights by signing it, and sign it freely and voluntarily, without inducement.

Participant's Signature

_____

Participant's Name (Printed)

_____

Witness's Signature _____ Date: _____

Personal Information:

Name: _____ Date of Birth: ____/____/____

Address: _____ Phone: _____

City/State/Zip: _____

Emergency Contact Person: _____

Emergency phone: _____ Relationship to emergency contact: _____

Liability Waiver:

I, the undersigned, being aware of my own health and physical condition, and having knowledge that my participation in any exercise program may be injurious to my health, am voluntarily participating in physical activity with Studio Fit

Having such knowledge, I hereby release Studio Fit, their representatives, agents, and successors from liability for accidental injury or illness which I may incur as a result of participating in the said physical activity. I hereby assume all risks connected therewith and consent to participate in said program.

I agree to disclose any physical limitations, disabilities, ailments, or impairments which may affect my ability to participate in said fitness program.

Signature: _____ Date:___/___/___

Studio Fit

Cancellation Policy

All cancellations must be received at least 12 hours before your training session in order to avoid being charged for your session. Clients who do not cancel with 12 hours notice will be charged for the cancelled session.

Studio Fit understands that emergencies happen. We provide every client with one free short-notice cancellation. You will not be charged for your first cancellation with less than 12 hour notice. Subsequent short-notice cancellations will be charged for the session. The free short-notice cancellation only applies if Studio Fit is notified prior to the session start time. No shows are not eligible for the free cancellation.

If you need to cancel a session, please call: 724-944-1660

Refund Policy

Studio Fit strives to provide the best possible service to our clients. If for any reason you are not satisfied with our services, we will be happy to issue you a refund for services ***not performed***.

If you have paid for a package in full, you will be refunded for unused sessions and services.

I have read the above policies and agree to its terms as it applies to my personal training.

Client Name: _____

Signature: _____Date: _____

Nutrition/Lifestyle Assessment Questionnaire

First Name: _____ Last Name: _____

DOB: _____ Today's Date: _____

Yes

No

Nutrition

How would you describe your nutrition habits? (Please Circle One)

Could Improve Average Above Average Great

Circle any of the following positive health changes that interest you:

Increased Energy	Increased Control of Blood Sugar
Decreased Body Fat	Decreased Blood Pressure
Increased Muscle Mass	Reduced Cholesterol
Other: _____	Other: _____

Are you on a special diet? ☐ ☐

If yes, who prescribed it?_____

Have you ever tried any "fad" diets? ☐ ☐

If yes, please list: _____

_____

How many meals do you usually eat per day? _____

Do you usually eat breakfast? ☐ ☐

Do you eat snacks? ☐ ☐

If yes, please list: _____

_____

Do you consume drinks other than water on a regular basis? ☐ ☐

If yes, please list: _____

_____

Do you drink alcohol? ☐ ☐

If yes, how many drinks per week?_____

Do you take any nutritional supplements (including vitamins & herbs)? ☐ ☐

If yes, please list: _____

_____

Would you like any information on any special nutrition topics? ☐ ☐

If yes, please list: _____

_____

Yes

No

Lifestyle

Do you currently participate in any organized sports (recreational or elite)? ☐ ☐

If yes, please list: _____

_____

What types of physical activities do you enjoy?

Please List: _____

_____

Age: _____ Weight: _____ Height: _____

Have you had any weight changes recently? ☐ ☐

If yes, please explain: _____

_____

Please rate your current stress level:

1 2 3 4 5

Low High

Have you been under stress lately? ☐ ☐

Do you sleep well? ☐ ☐

How many hours do you sleep per night? _____

Have you had any blood work done recently? ☐ ☐

If yes, would you mind sharing the results? (optional – bring to appointment) ☐ ☐

Is there anything else not addressed above that you would like to discuss? ☐ ☐

If yes, please explain: _____

_____

How did you hear about us, or who were you referred by? _____

_____

_____

*Thank you for taking the time to fill out this questionnaire. All answers are confidential and will not be released without your express written consent.

Goal Setting Worksheet

Time Commitment

Days of the week you can workout (circle all):

M Tu W Th F Sat Sun

Amount of time

each day (in minutes): | | | | | |

Barriers to Exercising

Circle all that apply and explain (be honest):

Time –

Work –

Family –

Travel –

Convenience –

Illness/injury –

Lack of enjoyment/discomforting –

Don't know what to do –

Doesn't work for me –

Others (list):

Goal Achievement Strategies (overcoming barriers)

Examples –

Block off your schedule at noon everyday to workout

Walk with office mate for half of lunch break.

1)

2)

3)

4)

5)

Set your Goals (be specific and realistic)

Short Term (up to 6 months)

Examples –

Walk at lunch for 30 minutes on M, W, & F

1)

2)

3)

Long Term (more than 6 months)

Examples –

Get down to my pre-pregnancy body weight of __ lbs.

Exercise 5 days every week

Look and feel good

1)

2)

3)

Rewards (for obtaining your goals)

1)

2)

3)

Additional Comments:

Health History Questionnaire

Please answer the following questions to the best of your ability. For the following questions, unless otherwise indicated, circle the single best choice for each question. As is customary, all of your responses are completely confidential and may only be used in group summaries and/or reports. All information collected is subject to the Privacy Act of 1974. If you have any physical handicaps or limitations that would require special assistance with this questionnaire, please let your trainer know. This form is in accordance with the American College of Sports Medicine guidelines for risk stratification when followed correctly by your trainer. Your trainer should be certified with a national organization in order to use these forms correctly.

Name:_____ Ht.:_____ Wt.:_____

Gender:_____ Age:_____ Birthdate:_____

Address: _____

City:_____ State:_____ ZIP:_____ Phone:_____

Emergency Contact:_____ Phone: _____

Personal Physician:_____ Phone:_____

E-mail:_____

1. Have you ever had a definite or suspected heart attack or stroke? .....Yes No

2. Have you ever had coronary bypass surgery or any other type of heart surgery? .....Yes No

3. Do you have any other cardiovascular or pulmonary (lung) disease (***other than*** asthma, allergies, or mitral valve prolapse)? .....Yes No

4. Do you have a history of: diabetes, thyroid, kidney, liver disease. .....Yes No
   (circle all that apply)

5. Have you ever been told by a health professional that you have had an abnormal resting or exercise (treadmill) electrocardiogram (EKG)? .....Yes No

6. If you answered YES to any of Questions 1 through 5, please describe:

_____

_____

_____

_____

7. Do you currently have any of the following:

a. pain or discomfort in the chest or surrounding areas that occurs when you engage in physical activity? ..... Yes No

b. shortness of breath ..... Yes No

c. unexplained dizziness or fainting ..... Yes No

d. difficulty breathing at night except in upright position ..... Yes No

e. swelling of the ankles (recurrent and unrelated to injury) ..... Yes No

f. heart palpitations (irregularity or racing of the heart on more than one occasion) ..... Yes No

g. pain in the legs that causes you to stop walking (claudication) ..... Yes No

h. known heart murmur ..... Yes No

Have you discussed any of the above with your personal physician? ..... Yes No

8. Are you pregnant or is it likely that you could be pregnant at this time? ..... Yes No
If yes, what is your expected due date?_____

9. Have you had surgery or been diagnosed with any disease in the past 3 months? ..... Yes No
If yes, please list date_____ and surgery/disease_____

10. Have you had high blood cholesterol or abnormal lipids within the past 12 months or are you taking medication to control your lipids? ..... Yes No

11. Do you currently smoke cigarettes or have quit within the past 6 months? ..... Yes No

12. Have your father or brother(s) had heart disease prior to age 55 OR mother or sister(s) had heart disease prior to age 65? ..... Yes No

13. Within the past 12 months, has a health professional told you that you have high blood pressure (systolic $\geq$ 140 OR diastolic $\geq$ 90)? ..... Yes No

14. Currently, do you have high blood pressure or within the past 12 months, have you taken any medicines to control your blood pressure? ..... Yes No

15. Have you ever been told by a health professional that you have a fasting blood glucose greater than or equal to 110 mg/dl? ..... Yes No

16. Describe your regular physical activity or exercise program:

type:_____

frequency: _____ days per week

duration: _____ minutes

intensity: *low* *moderate* *high* **(circle one)**

BMI: _____

17. If you have answered YES to any of questions 7-16, please describe:

_____

_____

_____

P04-020

18. Are you currently under any treatment for any blood clots? ..... Yes No

19. Do you have problems with bones, joints, or muscles that may be aggravated with exercise? ..... Yes No

20. Do you have any back/neck problems? ..... Yes No

21 Have you been told by a health professional that you should not exercise? ..... Yes No

22. Are you currently being treated for any other medical condition by a physician? ..... Yes No

23. Are there any other conditions (mitral valve prolapse, epilepsy, history of rheumatic fever, asthma, cancer, anemia, hepatitis, etc.) that may ***hinder*** your ability to exercise? ..... Yes No

24. During the past six months, have you experienced any ***unexplained*** weight loss or gain (greater than ten pounds for no known reason)? ..... Yes No

25. If you have answered YES to any of questions 18-24, please describe:

_____

_____

_____

26. Please list below all prescription and over-the-counter medications you are currently taking:

Medicine:	Reason for taking:	Dosage:	Amount/Frequency:

27. Are there any medicines that your physician has prescribed to you in the past 12 months which you are currently not taking? ..... Yes No
If so, please list:

_____

_____

_____

I have answered the Health History Questionnaire questions accurately and completely. I understand that my medical history is a very important factor in the development of my fitness/wellness program. I understand that certain medical or physical conditions which are known to me, but that I do not disclose to my trainer, may result in serious injury to me. If any of the above conditions change, I will immediately inform my trainer of those changes. I, knowingly and willingly, assume all risks of injury resulting from my failure to disclose accurate, complete, and updated information in accordance with the attached questionnaire. I also understand that in order to properly risk stratify my Health History Questionnaire, my trainer should have a minimum of a national certification as a personal trainer. My trainer also verbally explained this statement to me to my understanding.

Client's Signature:_____ Date: _____

Trainer's Signature:_____ Date: _____

For Use by the Personal Trainer ONLY

Check the identified ACSM major coronary risk factors below:

_____ Lipids (TCH ≥ 200 OR HDL < 35)
_____ Family History
_____ Diabetes/glucose ≥ 110 mg/dl
_____ BMI ≥ 30
_____ Metabolic Disease
_____ Signs or Symptoms of Cardiovascular Disease
_____ Cardiovascular Disease
_____ Cigarette Smoking (or quit within the past 6 months)
_____ High Blood Pressure/Blood Pressure Medications
_____ Sedentary
_____ Pregnancy
_____ Respiratory Disease (asthma, emphysema, chronic bronchitis)

Risk Stratification	**Factors**
_____ Apparently Healthy	One or No Risk Factors (No medical clearance required)
_____ Apparently Healthy Male ≥ 45; Female ≥ 55	One or No Risk Factors (Initial medical clearance required)
_____ High Risk, No Signs or Symptoms	Two or More Risk Factors (medical clearance required)
_____ High Risk, with Signs and Symptoms	One or More Signs/Symptoms With or Without Risks (medical clearance required)
_____ Known Disease	Diagnosed Cardiopulmonary/Metabolic Disease (annual medical clearance required)
_____ Pregnancy	Medical Clearance Required

All clients needing written medical clearance from their personal physician must give it to their trainer prior to beginning their exercise program.

Additional Comments: _____

Health History Questionnaire follows the American College of Sports Medicine recommendations for risk stratification. This must be performed on all clients in order to determine the need for medical clearance and/or exercise modifications. Any trainer or those making exercise recommendations should be certified in the proper use of the risk stratification process through a national organization.

If a client has a YES response to anything on page 1, he/she has KNOWN DISEASE, and must have medical clearance prior to beginning exercise.

If he/she has a YES response to anything on #7 a-h on page 2, your client is HIGH RISK WITH SIGNS/SYMPTOMS and must have medical clearance prior to exercise. If your client has a YES response to questions # 8 or 9, he/she must have medical clearance.

YES responses to two or more on questions 10-16 on page 2, your client is HIGH RISK WITHOUT SIGNS OR SYMPTOMS and must have medical clearance (unless he/she also has a YES answer in question #7 making them still HIGH RISK WITH SIGNS/SYMPTOMS).

All other questions on page 3 are at your own discretion. Remember, **when in doubt, refer out.** Please also refer to the most recent edition of *ACSM's Guidelines for Exercise Testing and Prescription* (Williams & Wilkins) as well as the most recent edition of the *ACE Personal Trainer Manual* (American Council on Exercise) for more explanations on the risk stratification. It is your responsibility as a trainer to remain updated on all changes or modifications for risk stratification in determining the need for medical clearance and exercise modifications/recommendations.

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