



# LIFECENTER

HEALTH & FITNESS CLUB

## REQUEST FOR PERSONAL TRAINING





# Request for Personal Training

Name \_\_\_\_\_

Cell Number \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_

Email \_\_\_\_\_

Home Number \_\_\_\_\_

Birthdate \_\_\_\_\_

## Emergency Contact:

Name \_\_\_\_\_ Cell Number \_\_\_\_\_

Trainer Preference:    **MALE**                      **FEMALE**                      **SPECIFIC:** \_\_\_\_\_  
(Name of trainer)

Days & Times of Week Preferred: \_\_\_\_\_

## Personal Information:

1. Height \_\_\_\_\_ Weight \_\_\_\_\_ Ideal Weight \_\_\_\_\_

2. How long have you been at your current weight? \_\_\_\_\_

3. How often are you presently exercising? \_\_\_\_\_ days/week \_\_\_\_\_ minutes/day

4. How often do you want to exercise? \_\_\_\_\_ days/week \_\_\_\_\_ minutes/day

5. What are your goals (short term & long term)?

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

6. Do you want to do cardiovascular training, i.e. treadmill, aerobic classes?                      Y    N  
\_\_\_\_\_ days/week                      type: \_\_\_\_\_

7. Do you want to do strength training?                      Y    N                      \_\_\_\_\_ days/week

8. When was the last time you were exercising on a consistent basis? \_\_\_\_\_

9. What type of exercising were you doing? \_\_\_\_\_

10. How experienced are you with cardiovascular training?                      Basic                      Moderate                      Advanced

11. How experienced are you with strength training?                      Basic                      Moderate                      Advanced

12. Do you have any exercise limitations, i.e. back pain, shoulder surgery?                      Y    N  
If yes, please list: \_\_\_\_\_

13. Please describe a typical day's meals:

Breakfast: \_\_\_\_\_

Dinner: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Lunch: \_\_\_\_\_

Snacks: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

14. Do you skip meals? Y    N    If so, which ones? \_\_\_\_\_

15. How much water do you drink in 1 day? \_\_\_\_\_ cups/day

16. Do you have any dietary restrictions?                      Y    N                      If yes, please list: \_\_\_\_\_

\_\_\_\_\_

## LIFECENTER Personal Training Client Guidelines

- Payments must be made 24 hours in advance of the session
- If a session needs to be cancelled by the Client, the Client must contact the Trainer either by **LIFECENTER** Voicemail # \_\_\_\_\_ or Trainer's personal phone # \_\_\_\_\_ or **LIFECENTER** Front Desk 630-540-4848 as soon as possible
- If cancellation notice is not given prior to 24 hours of scheduled appointment, the appointment will be charged the full cost of the training session
- If the Client is more than 15 minutes late, the session is considered missed and will be charged the full cost of the training session
- If the Client is running late, please contact the **LIFECENTER** Front Desk 630-540-4848 and have the Trainer advised
- Sessions are scheduled for 30 or 60 minutes, if the Client is late for the scheduled appointment, it is not the Trainer's obligation to continue training past the original ending time
- If the Client is forced to cancel due to an emergency, the charges will be waived for that training session
- If the Trainer is late for the scheduled appointment, it is the Trainer's responsibility to make up that time. Please understand it may not be possible on that particular day

I have read and understand the terms of this contract. If for any reason the Client/Trainer relationship is not conducive to a productive personal training session, the Client/Trainer has the right to terminate this contract at anytime. Notice must be given to the Fitness Coordinator verbally or in writing immediately.

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Trainer Signature

\_\_\_\_\_  
Date

### FOR OFFICE USE ONLY

	Date	Time of Call	Spoke With	Call Results
1.				
2.				
3.				

**Notes:**



## Health History Questionnaire

www.lifecenterfitness.org

Regular physical activity is safe for most people. However, some individuals should check with their doctor before they start an exercise program. To help us determine if you should consult with your doctor before starting to exercise with LIFECENTER, please read the following questions carefully and answer each one honestly. All information will be kept confidential.

**YES NO**

**Section I**

One or more "YES" needs medical release

- |                          |                          |   |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Do you have a heart condition?   |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Have you ever experienced a stroke?  |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. Do you have epilepsy?  |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. Are you pregnant?  |
| <input type="checkbox"/> | <input type="checkbox"/> | 5. Do you have diabetes?  |
| <input type="checkbox"/> | <input type="checkbox"/> | 6. Do you have emphysema?   |
| <input type="checkbox"/> | <input type="checkbox"/> | 7. Do you have chronic bronchitis?  |
| <input type="checkbox"/> | <input type="checkbox"/> | 8. Have you had a graded treadmill test/stress test prescribed by a doctor in the past 12 months?           |
| <input type="checkbox"/> | <input type="checkbox"/> | 9. In the past 12 months, has a physician ever told you or are you aware that you have high blood pressure? |

**YES NO**

**Section II**

Three or more "YES" needs medical release

- |                          |                          |  |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | 10. Do you feel pain in your chest when you engage in physical activity?   |
| <input type="checkbox"/> | <input type="checkbox"/> | 11. In the past month, have you had chest pain when you were not doing physical activity?  |
| <input type="checkbox"/> | <input type="checkbox"/> | 12. Do you ever lose consciousness or do you ever lose control of your balance due to chronic dizziness?   |
| <input type="checkbox"/> | <input type="checkbox"/> | 13. Are you currently being treated for a bone or joint problem that restricts you from engaging in physical activity?                               |
| <input type="checkbox"/> | <input type="checkbox"/> | 14. Has anyone in your immediate family (parents/brothers/sisters) had a heart attack, stroke, or cardiovascular disease before age 55?              |
| <input type="checkbox"/> | <input type="checkbox"/> | 15. Has a physician ever told you or are you aware that you have high cholesterol level?   |
| <input type="checkbox"/> | <input type="checkbox"/> | 16. Do you currently smoke?  |
| <input type="checkbox"/> | <input type="checkbox"/> | 17. Are you a male over 44 years of age?   |
| <input type="checkbox"/> | <input type="checkbox"/> | 18. Are you a female over 54 years of age?   |
| <input type="checkbox"/> | <input type="checkbox"/> | 19. Are you currently exercising <i>LESS</i> than 1 hour per week? If you answered no, please list your activities.                                  |
| <input type="checkbox"/> | <input type="checkbox"/> | 20. _____<br>Any other medical conditions? ( <i>Surgical procedures, injuries, etc...</i> )<br>If yes, please list below:<br>_____<br>_____<br>_____ |

# Medications

## Section III

<b>Do you take any of the following medications?</b> <i>(Doctor Prescribed)</i>		
For the <i>Heart</i>	YES	NO
If YES, what type? _____		
For <i>High Blood Pressure</i>	YES	NO
If YES, what type? _____		
For <i>High Cholesterol</i>	YES	NO
If YES, what is your Total Blood Cholesterol? _____		
For <i>Diabetes</i>	YES	NO
If YES, what type? _____		
For <i>Stroke</i>	YES	NO
If YES, what type? _____		

<b>Are you currently taking any other medications?</b>	
<u>Medication</u>	<u>Purpose</u>
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

I understand that any exercise program I undertake may create physical stress and subsequent harmful effects. I agree that it is solely my responsibility and not the responsibility of **LIFECENTER** to require me to consult with a physician prior to commencing any exercise program, to remain under medical supervision if that is indicated, and to seek medical assistance in the event of an injury. I recognize that the use of equipment entails some risk of accidental injury to myself and to others and I agree that I will use such equipment and facilities with due care. I have read, understood, and completed this questionnaire. Any questions that I had were answered to my full satisfaction.

Name \_\_\_\_\_

Date \_\_\_\_\_

Signature \_\_\_\_\_

..... **Staff Use Only** .....

<input type="checkbox"/> Cleared to Exercise	<input type="checkbox"/> Not Cleared to Exercise/ Needs <i>Medical Release</i>
[Section I] [Section II] [Section III]	
Staff Signature _____	
Date _____	

## How to Prepare for Your Fitness Assessment

Fitness Testing will be conducted in the Assessment Office.

The assessment will be conducted in private.

- Y Please be aware that your Health Assessment is not a medical stress test and does not replace that need to have regular physicals with your physician.
- Y Please arrive 10 minutes early to allow time for check-in. When you arrive, check in at the **LIFECENTER** front desk.
- Y In order to assure that the results of your fitness assessment are as accurate as possible, please review the following guidelines. Your assessment will be given on the assumption that you have followed these recommendations.

1. Please refrain from smoking and the consumption of caffeine 2 hours prior to your fitness assessment.
2. It is important that you have energy for your fitness assessment, so you may eat something light before your assessment. Please do not eat a heavy meal before the assessment
3. Refrain from exercise on the day of your assessment.
4. Wear loose fitting workout clothes (jogging attire, shorts, training shoes, etc.) Because of the body fat measurement, it is advisable to wear shorts. Do not wear tights.
5. Fill out the attached paperwork. The personal trainer will go over with you to help you make any positive lifestyle changes.