Personal Training

Client: ____

Trainer: ______________________________(To be filled in by staff)

Appointment: _______________________(To be filled in by staff)

- ❒ FREE— 4 Week Initial Training Program **(Active Duty, Active Reservist)**
- ❒ $50— 4 Week Initial Training Program (**AD Dep, Ret, Ret Dep**)
- ❒ $60— 4 Week Initial Training Program (**DOD, MCCS Emp**)
- ❒ $25ea.— 4 Week Buddy Training (**AD Dep, Ret, Ret Dep**)
- ❒ $30ea.— 4 Week Buddy Training (**DOD, MCCS Emp**)
- ❒ FREE—HITT Lite (**Active Duty, Active Reservist only**)

***PLEASE NOTE:* Due to HITT coach led sessions personal training is not offered 0600-0700 and 1130-1230.**

- First time assessments and meetings are held in the PT assessment room in the Marine Dome (room 20)
- Please wear athletic attire and appropriate footwear. There are locker rooms in the building if you need to change your clothing.
- Please refrain from any caffeine, nicotine products and physical exercise for a **minimum of two hours prior** to your initial assessment.
- If you have any questions or need to reschedule the appointment, please call the Personal Training office at 466-2371 or 466-7201.
- Clients cannot drop from the initial program and resume at a future date unless authorized by their trainer.
- No refunds will be given for incomplete sessions.
- Training sessions must be completed within 4 weeks unless authorized by the trainer.

Name: ____ **PIN#** (choose 4 #'s) ____________

Rank/Affiliation: ____________**Unit:** _______________**Age:** ________**DOB:** ______________

Phone Number: Work ______________________ Home/Cell ___________________________

Email: ____

PERSONAL HEALTH ASSESSMENT

(After review, a doctor's clearance may be required before assessment can be conducted.)

Please check all that apply (currently or previously treated for)

_____Disease of the heart or arteries
_____Abnormal electrocardiogram (EKG)
_____High blood pressure
_____Angina pectoris (chest pain)
_____Epilepsy
_____Stroke
_____Anemia
_____Diabetes
_____Abnormal chest x-ray
_____Cancer
_____Asthma
_____Other lung disease
_____Orthopedic or muscular problems
_____Currently in physical therapy (or discharged within the past 3 months)
_____Currently on light or limited duty (copy of form is needed)

If you checked yes to any of the above, please elaborate and indicate any recommendations your doctor made regarding exercise.

____

____

Are you currently taking medication prescribed by a physician? YES_____ NO_____ If yes, indicate name of medication, dosage, and reason you are taking it.

____

____

Do you currently smoke cigarettes or use any tobacco product? YES_____ NO______

If yes, how many cigarettes/dip, etc. a day? __________
If you smoked in the past, when did you quit? __________

Please indicate below any additional medical information that you think is important for us to be aware of prior to fitness testing or exercise.

____

____

____

PHYSICAL ACTIVITY

What best describes your physical activity level during the past 3 months?

_____Very Active _____Moderately Active

_____Occasionally Active _____Inactive

Please describe your current workout routine. ____

____

____

ADDITIONAL INFORMATION

What are your goals; what are you looking to achieve with this exercise program? Please be as specific as possible. *For example: I would like to lose 20 lbs. in 4 months; I would like to finish a 5k race in 25 minutes in 6 weeks; etc.*____

____

____

What days of the week and times of day are you available to work with a trainer? Please list all available days/times____

____

____

Please list below any additional exercise or goal information which you think is important for us to know prior to fitness testing or exercise. ____

____

____

INFORMED CONSENT

The undersigned hereby gives informed consent to engage in a series of procedures relative to completing a written medical / health history, taking a battery of exercise tests and participating in a variety of exercise activities. The purpose of the testing is to determine physical fitness, cardiovascular function and health status. All exercise testing and physical activity sessions will be supervised and monitored by trained exercise technicians. These activities include walking, running, weight training, calisthenics and exercises performed in either field or gymnasium settings.

There exists the possibility that certain detrimental physiological changes may occur during exercise and exercise testing. These changes could include heat related illness, abnormal heart rates, abnormal blood pressure, and in rare instances, heart attacks. If abnormal changes were to occur the staff has been trained to recognize symptoms and take appropriate action, including administering CPR and first aid.

I have read this form and understand that there are inherent risks associated with any physical activity and recognize it is my responsibility to provide accurate and complete medical history information. Furthermore, it is my responsibility to monitor my individual physical performance during any activity.

In the event of a medical situation, I further recognize that any medical care that may be required, is my personal and financial responsibility. Finally, I give informed consent for testing data to be used in an anonymous manner for purposes of scientific and medical research.

Signature ____ Date ____________________