City of Redwood Falls
Parks & Recreation

RACC Fitness Assessment & Personal Training Packet

The fitness assessment will include the following tests:
Body Composition, Strength, Flexibility, Height, Weight, and Cardiovascular

EACH ASSESSMENT AND PERSONAL TRAINING SESSION WILL TAKE 1-HOUR AND MUST BE SCHEDULED IN ADVANCE.

PACKAGE	MEMBER PRICE	NON-MEMBER PRICE
Fitness Assessment	$25/Session	$30/Session
Personal Training Package	$40.00/2-1 Hour Sessions	$40.00/2-1 Hours Sessions

ANY CANCELLATIONS MADE LESS THAN 24 HOURS BEFORE THE APPOINTMENT WILL BE CHARGED A $20 FEE.

Client's Name:			
Address:			
City, State, Zip Code:			
Home Phone Number:		Work Phone:	
Cell Phone Number:			
Email Address:			
Date of Birth:			
Client's Signature:		Date:	

Dates & Times Requested by Client:	
Date:	Time:

Authorization for Disclosure of Information

(Pursuant to the Privacy Act of 1974, Public Law 93-579 5 USC 552a)

TO: **____ Personal Trainer** **____ Other**

_____
Name

_____
Address

You are hereby authorized to furnish information from the record of the individual named below in the _____ record system of your facility to (print or type name, title, and address below):

1. Name of client or subject individual (print or type):_____

2. Purpose or need of the Disclosure (please check)

_____ Compensation claim(s)

_____ Insurance claim (s)

_____ Private Physician

_____ Attorney

_____ Other

_____ Self

3. Specify extent and nature of information to be disclosed for each purpose or need indicated (SPECIFY inclusive dates: From_____ To _____

If this authorization has not otherwise been revoked or has not expired in accordance with the terms of the duration statement provided above or has not been given for a longer period as set forth in the duration statement, it will terminate **one year** from the date of the signature.

Any person who knowingly and willfully requests or obtains any record concerning an individual under false pretenses shall be guilty of a misdemeanor and fined not more than $5,000.00 (5USC 552a(I)(3)) and in the case of alcohol and drug abuse patient records a falsified authorization of disclosure is prohibited under 42CFR2.31(d) and is punishable by a fine of not more that $500 for a first offense or a fine of not more than $5,000 for a subsequent offense in accordance with 42CFR2.14.

4. Signature:	5. If other than subject, indicate relationship or authority	6. Date
7. Parent or Guardian if a minor:		

(404) 406-2873

Client _____

Date _____

Goal Inventory

1. SMART Goals:

Write your SMART Goal:	

Action Steps/Coaching tips	Actions- Comments
Specific - Need to be specific on what you want to accomplish. Try to summarize it in one thought.	
Measurable – Put numbers to reach your goal. Can you determine how to quantify your outcome? Will you know that you have reached your goal? What affect will your goal have on your life?	
Attainable – Phrase your goals that only you depend on yourself and not others to achieve this goal? Are there obstacles that prevent you from reaching your goal?	
Relevant – Make your goals relevant to you. Is there anything else that is important and you have not shared? What would you like to change the most?	
Time-Specific – What is the time frame that you will reach this goal? How long to create and uphold a habit in this area?	

2. "I think that my exercising at least four days a week, every week, is highly likely." With respect to yourself, do you (Please circle the appropriate #).

   Strongly agree Agree Disagree Strongly Agree

   If you circled 3 or 4 why? (Please be as specific as possible)

3. When I reach this goal, here's what I will get and how I will feel:

4. What are you looking for from the trainer? Why do you want a trainer?

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 which 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:**_____ **Occupation:**_____

Address:_____

City:_____ **State:**_____ **Zip:**_____ **Phone:**_____

Emergency Contact:_____ **Phone:**_____

Personal Physician:_____ **Phone:**_____

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, asthma, or chronic bronchitis (***other than*** allergies)?……..……...…Yes No
4. Have you ever had a history of diabetes, thyroid, kidney, or liver disease? (please circle which one) ……..…… Yes No
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 you 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 cholesterol or abnormal lipids within the past 12 months or are 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 ≥ 140 OR diastolic ≥ 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: l*ow* *moderate* *high* **(circle one)**
    - _____BMI

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

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 HHQ 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 which 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 HHQ, 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:**_____

(404) 406-2873

For Use by the Personal Trainer ONLY

Check the identified ACSM major coronary risk factors below:

___ Lipids (TCH ≥ 200 OR HDL < 40)
___ Cigarette Smoking (or quit within the past 6 months)
___ Family History
___ High Blood Pressure/Blood Pressure medications
___ Diabetes/glucose ≥ 110 mg/dl
___ Sedentary
___ BMI ≥ 30
___ Signs or Symptoms of Cardiovascular Disease_____
___ Cardiovascular Disease_____
___ Pregnancy

	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 your trainer prior to beginning their exercise program.

Additional Comments:_____
_____
_____

(404) 406-2873

EXERCISE SESSION LOG

Client's Name_____ **Date:**_____

Complaints/Concerns Prior to Exercise Session:_____

Exercise Program for Today:_____

Complaints/Concerns During/After Exercise Session:_____

Check Appropriate Boxes to indicate "Completed"

Warm-up	**Exercise according to Dr.'s recommendation/clearance &/or ACSM/ACE Guidelines**
Stretches	
Cool-down/stretches	**Other:**_____

Other Comments/Concerns:_____

_____ _____

Personal Trainer's Signature **Date**

INCIDENT REPORT

Name:_____ **Date**_____

Work Phone:_____ **Home Phone:**_____

Report of Incident:_____

Date of Incident:_____ **Time of Incident:**_____

Location of Incident:_____

Response/Treatment to Incident:_____

Witness:_____ _____

(Printed Name) **(Phone Number)**

_____ _____

(Signature) **(Date)**

Staff: _____ _____ _____

(Printed Name) **(Signature)** **(Date)**

Follow Up (Staff member_____**)** **Date**_____

Staff Signature

Make one copy of this report. Keep the original in the client's file, keep the copy in an incident report file.

CONSENT FOR EXERCISE PROGRAM

Exercise Objectives: The purpose of an exercise program is to develop and maintain cardiorespiratory (aerobic) fitness, muscular, strength and endurance, body composition, and flexibility. These recommendations follow industry standards and should be conducted under the supervision of a trainer with a minimum of a national certification.

Procedures: A structured exercise program based on individual needs (obtained fitness assessment information), interests, and/or physician's recommendations will be given to each participant. Exercises may include aerobic activities (treadmill walking/running, cycling, rowing machine exercise, group aerobic activity, swimming, and other such activities), calisthenics and weight lifting to improve muscular strength and endurance, and flexibility exercise to improve joint range of motion. All aerobic programs involve a warm-up, exercise at target heart rate, and cool down components and follow American College of Sports Medicine's recommendations.

Potential Risks: All exercise programs/testing are designed to place a gradually increasing work load on the cardio-respiratory and musculoskeletal systems in order to effect improvements. The body's reaction to gradually increasing exercise activities cannot be predicted with complete accuracy. Unusual changes during or following an exercise session may occur. These may include muscular of joint injury, abnormal blood pressure, fainting, disorders of heart beat, and/or very rare instances of heart attack or death.

Potential Benefits: Benefits obtained from a structured and regularly employed exercise program might include a more efficient cardiorespiratory system, an improved musculoskeletal system, a decrease in body fat, a decrease in blood fats, an improvement in psychological function, and a decrease in the risk of heart and other diseases.

Supervision: Your trainer is not responsible for injuries and/or damages that occur when the facility/individual(s) are not supervised by your trainer or during non-operational hours.

Confidentiality: All participant exercise program information will be treated as privileged and confidential and will not be revealed to any person (other than your trainer involved in the participant's exercise program) without expressed written consent. Obtained information, however, may be used for statistical or scientific purposes with right to privacy retained.

Inquiry and Freedom of Consent: I have read the foregoing and I understand the objectives, procedures, potential risks and benefits, supervision issues, and confidentiality involved. Unless otherwise indicated under the "comments" section below, I certify that I am in good health and have no condition that would limit/prohibit my participation in a structured exercise program. I understand that if there are any questions about the procedures or methods used during an exercise session, I should ask my trainer. I realize that injury may result from improper exercise techniques or misuse of exercise facilities or equipment. I agree to be attentive to all instructions given to me and to exercise and use facilities and equipment correctly. I assume responsibility for monitoring my own condition throughout the exercise program and should any unusual symptom(s) occur, I will cease my participation and inform my trainer. I shall also notify my trainer of any changes in my medical status. I consent to the administration of any immediate resuscitation measures deemed advisable by my trainer or other qualified personnel.

Q u e s t i o n s / Comments:_____
_____
_____

I have read and understand the above information and voluntarily consent to participate in a structured exercise program. I realize that I am free to terminate the exercise program at any time.

Printed Name: X_____
Signature: X_____ **Date:**_____
Witness: _____ **Date:**_____

FITNESS PROFILE

CLIENT NAME_____**TESTER:**_____**DATE:** _____

AGE: _____ **SEX:** _____ **M** _____**F** **HEIGHT** _____**ft.** _____**in** **WEIGHT**_____

TRAINING PARAMETERS

Resting BP: _____/_____ Resting Heart Rate:_____

Training Zone (%VO2) _____% Lower - _____% Upper

YMCA Bike Test 1st HR_____ 1st KPM_____
2ndHR_____ 2nd KPM_____ Max VO2_____

RockPort Walk Test: _____ min. _____ sec. _____ HR (bpm) Max VO2_____

3-Minute Step Test _____min. _____sec. _____HR (bpm)

GIRTH MEASUREMENTS:

ARM_____in
(Measure on right side of body with arms at side)

CHEST_____in
(Arm should be relaxed at side of body)

WAIST_____in
(Measure on right side of body over the umblilicus)

HIPS _____in
(Measure on right side of body)

THIGH _____in
(Measure on right leg below gluteal fold)

CALF _____in
(Measure on right leg at largest circumference)

SKINFOLD MEASUREMENTS:

CHEST _____mm
(Fold equidistant from anterior axillary line & nipple)

TRICEP _____mm
(Fold equidistant from the olecranon & acromion)

SCAPULA _____mm
(Fold taken 3 cm medially of posterior prominence)

AXILLA _____mm
(Vertical fold from lateral line of xiphoid)

ABDOMEN _____mm
(Vertical fold 3cm. From the umbilicus)

ILIUM _____mm
(3 cm above and anterior to iliac crest)

THIGH _____mm
(Fold equidistant between hip & knee

BODY COMPOSITION_____%

MUSCULOSKELETAL FITNESS

SIT AND REACH _____in HAMSTRING TEST_____ degrees

SHOULDER FLEXIBILITY _____in.

PUSH UP TEST _____reps YMCA BENCH PRESS _____reps

BENT KNEE CURL UP _____ reps

Personal Training Agreement

By signing this agreement below, I am agreeing to the following terms of personal training:

_____ I agree to pay for all personal training sessions in full prior to scheduling my first appointment.
initials

_____ I understand that the discounted prices are applicable only if I pay for the multiple sessions in full prior to my first appointment using those multiple sessions.
initials

_____ I understand that in order for me to cancel an appointment and not be charged, I must call my trainer at least ____ hours prior to my appointment._____
initials
Phone Number

_____ If I arrive more than 15 minutes late for my appointment, then I forfeit that training time and will be charged for that session.
initials

_____ I understand that every effort will be made to accommodate my preference for my appointment time as well as the specific trainer I request, but due to other appointments, health fairs, etc. it may not always be possible.
initials

_____ I understand that if I have not disclosed known medical information about myself to the staff/personal trainer that it may affect my ability to exercise and that my trainer will not be held responsible for injuries, illnesses, or negligence that occurs due to that lack of information.
initials

In signing below, I agree to the above conditions for personal training as well as all other policies of the facility.

_____ _____
Signature Date

_____ _____
Printed Name (W) Phone Number

_____
(H) Phone Number

_____ _____
Staff/Personal Trainer Date

Waiver Form

This form is an important legal document. It explains the risks you are assuming by beginning an exercise program. It is critical that you read and understand it completely. After you have done so, pleases print your name legibly and sign in the spaces provided at the bottom.

Wavier and Covenant Not to Sue

I,_____, have volunteered to participate in a program of physical exercise under the direction of (RACC), which will include, but may not be limited to, weight and /or resistance training. In consideration of (RACC), agreement to instruct, assist and train me, I do here and forever release and discharge and hereby hold harmless (RACC), and their respective agents, heirs, assigns, contractor, and employees from any and all claims, demands, damages, rights of action or causes of action, present or future, arising out of or connected with my participation in this or any exercise program including any injuries resulting there from.

Assumption of Risk

I,_____, recognize that exercise might be difficult and strenuous and that there could be dangers inherent in exercise for some individuals. I acknowledge that the possibility of certain unusual physical changes during exercise does exist. These changes included abnormal blood pressure, fainting, disorders in heartbeat, heart attack, and in rare instances death.

I understand that as a result of my participation in an exercise program. I could suffer an injury or physical disorder that could result in my becoming partially or totally disabled and incapable of performing any gainful employment or having a normal social life.

I recognize that all participants prior to involvement in any exercise program should obtain an examination by a physician. If I ,_____, have chosen not to obtain a physician's permission prior to beginning this exercise program with (RACC), I hereby agree that I am doing so at my own risk

In any event, I acknowledge and agree that I assume the risks associated with any and all activities and /or exercises in which I participate.

I acknowledge and agree that no warranties or representations have been made to me regarding the results I will achieve from this program. I understand that results are individual and may vary.

_____ _____

Participant's Signature Date

_____

Please Print Name

PHYSICIAN REFERRAL

Date Faxed/Sent to Physician_____

Patient_____ Physician_____
Birthdate_____ Phone _____
Phone_____ Fax_____

Dear Doctor,

Your patient has requested to participate in an exercise program. This referral is requested for establishing medical clearance to provide initial fitness assessments for beginning an exercise program.

Due to the reasons listed below, we are requesting medical clearance for your patient. Please complete the following form and state to the best of your ability if there are any contraindications or recommendations for participation in the testing procedures or exercise program. This form is administered based on established guidelines of the ACSM (American College of Sports Medicine). This referral is valid only if the client remains on the same medications (type and dose), and is in the same clinical status as on the day of the fitness assessment. The client has signed a statement that it is his/her responsibility to inform the trainer of any changes in their health status. Thank you.

Primary Risk Factors noted on Health History Questionnaire**(for the Trainer only)**:

_____elevated cholesterol _____cigarette smoking _____high BP/BP meds

_____sedentary _____metabolic disease _____CV/Respiratory disease

_____age (males>45/women > 55) _____family history _____pregnancy

_____ BMI ≥ 30 _____signs or symptoms_____

_____

Other information:_____
_____

Based on the information provided and any other information you, the physician, may have concerning your client, **your recommendations for exercise (check ONE):**

1. _____is **NOT CLEARED** and cannot exercise at this time.
2. _____ is CLEARED and can exercise with no restrictions
3. _____ is CLEARED with the following RESTRICTIONS_____

_____

_____ _____
Physician's Signature Date

Please return within 1 week from date noted above