Personal Training/ Pilates Data Sheet

Name: _____

Date of Birth: _____ Age: _____

Address: _____

Street City State Zip Code

Contact Number (best): _____Circle one: (Home/Cell/Work)

Contact Number (alternative)_____Circle one: (Home/Cell/Work)

Email: _____

Male Female

In case of emergency, please contact:

Name: _____ Relationship: _____

Address: _____

Phone: _____

Physical Activity Readiness Questionnaire (PAR-Q)

Regular exercise is associated with many health benefits. Increasing physical activity is safe for most people. However, some individuals should check with their physician before they become more physically active. Completion of this questionnaire is a first step when planning to increase the amount of physical activity in your life. Please read each question carefully and answer every question honestly.

Yes	No	Has a physician ever diagnosed you with a heart condition and recommended only medically supervised physical activity?
Yes	No	When you perform physical activity, do you feel pain in your chest?
Yes	No	Do you ever faint or get dizzy and lose your balance, or consciousness?
Yes	No	Do you have a bone or joint problem that could be aggravated by physical activity?
Yes	No	Do you have high blood pressure or a heart condition for which a physician is currently prescribing a medication?
Yes	No	Are you pregnant or have you given birth within the last 6 months?
Yes	No	Do you have insulin dependent diabetes, or do you have hypoglycemia?

Yes	No	Do you suffer from exercise-induced asthma?
Yes	No	Are you 65 years of age or older and not used to being very active?
Yes	No	Have you had a recent surgery, and/or are you on any medication?
Yes	No	Have you had a stroke?
Yes	No	Are you aware, through your own experience or a doctor's advice, of any other physical reason against your exercising without medical supervision?
Yes	No	Have you consulted your physician regarding increasing your physical activity and/or performing a fitness assessment?
Yes	No	If you answered NO to the previous question, will you consult your physician prior to increasing your physical activity and/or performing a fitness assessment?

If you answered yes to any of the above questions, talk with your doctor before you become more physically active. Tell your doctor your plan to exercise and to which questions you answered yes. If you honestly answered no to all questions you can be reasonably certain you can safely increase your level of physical activity gradually. If your health changes so you then answer yes to any of the above questions, seek guidance from a physician.

Participant's Signature:_____**Date:**_____

Personal Medical History

Have you ever had (or currently have) any of the following? (please check all that apply)

Heart Attack Stroke Shortness of Breath Angina Diabetes

Rheumatic Fever High Blood Pressure Gout Heart Murmur

High Cholesterol Rapid Heart Beats at Rest Skipped Heart Beats Extra Heart Beats

If yes, please explain:

_____

Are you currently taking any medication (depression/High BP)? Yes No

If yes, please list and explain:

_____

Family History

Please put a check in front of any statements that apply to your family history.

Parent died of heart attack prior to age 50 Parents, siblings with stroke

Sibling died of heart attack prior to age 50 Parents, siblings with diabetes

Parents, siblings with high blood pressure Other

Please explain:

_____

Personal Pulmonary Hygiene

Have you ever had (or currently have) any of the following? (please check all that apply)

Asthma Bronchitis Home Oxygen Emphysema

Tuberculosis Pneumonia Allergies

If yes, please explain:

_____

Muscular/Bone/Joint History

Have you ever had (or currently have) any of the following (please check all that apply)?

Arthritis Knee problems Back injury/problems Muscular pain/injuries

Muscular Weakness Hip problems Painful joints Tendonitis

If yes, please explain:

_____

Other Medical Questions

Have you ever had (or currently have) any of the following? (please check all that apply)

Dizziness Blood Disorder Lyme Disease Epilepsy Nervousness

Convulsions Cancer Headaches Kidney Disease Anemia

Thyroid Disorder Depression Other

If yes, please explain:

_____

Have you had surgery or been in a hospital for medical treatment? o Yes o No

If yes, please explain:

_____

Are you under any type of medical observation or receiving treatment? o Yes o No

If yes, please explain:

_____

Do you smoke? Yes No How many cigarettes, packs per day? _____

Do you drink alcohol? Yes No

Do you currently exercise? Yes No

Exercise Goals and Intent

What is your main goal for exercising?

Weight Loss Building muscle Shaping & toning Building strength

Weight gain Overall health Lower blood pressure/cholesterol

If other, please explain:

_____

In 6 months, how would you like to describe your body, physical vitality, or performance?

_____

Why is this outcome important to you?

_____

How long have you been thinking about getting into better shape?

_____

How do you envision your trainer facilitating your success?

_____

What are your short -term goals?

_____

What are your long -term goals?

_____

How will you reward yourself for reaching your short- term goals?

_____

What will be your reward for reaching your long- term goals?

_____

How many times per week are you interested in exercising?

Circle one: 1 2 3 4 5 6 7

When are you interested in training?

Circle all that are convenient for you:

Days: M T W Th F Sa Su

Times: 7:30-9:00am 9:00am-12pm 12pm-3pm 3pm-5pm

INFORMED CONSENT RELEASE OF LIABILITY

I hereby voluntarily give consent to engage in physical fitness. I understand there are certain changes which may occur during exercise. They include abnormal blood pressure, fainting, disorders of heartbeat, and exceedingly rare instances of heart attack. I understand that every effort will be made to minimize problems during exercise.

I understand that I am responsible for monitoring my own condition when exercising, and should any unusual symptoms occur, I will cease my participation and inform the trainer of the symptoms. Unusual symptoms include, but are not limited to chest discomfort, nausea, difficulty in breathing, and joint or muscle injury. Also, in consideration of being allowed to participate in the fitness tests, I agree to assume all risks of such exercise, and hereby release and hold harmless the The Pilates Movement, PJ Isaac and their agents and employees, from any and all health claims, suits, losses, or causes of action for damages, for injury or death, including claims form negligence, arising out of or related to my participation in physical fitness.

I have read the foregoing carefully and I understand its content. Any questions which may have occurred to me

concerning this informed consent have been answered to my satisfaction.

Name: _____ Date: _____

Witness: _____ Date: _____

CANCELLATION POLICY

There is a 24-hour cancellation policy for private, semi-private, and group sessions. If not cancelled within 24 hours you will be subject to be charged for the missed session.

Name: _____ Date: _____

Medical Clearance Form

Name: _____

Date of Birth:_____

Signature: _____ Today's Date:_____

Physician's Clearance Form

On the Physical Activity Readiness Questionnaire you just completed, you either indicated that you were at least 70 years old or you identified that you have one or more medical risk factors, which may impair your ability to exercise safely. Therefore, you must have a physician complete and return this medical clearance form before you can begin/ continue exercising. We recognize that you are eager to participate in a fitness program, and we sincerely regret any inconvenience that this may cause you. However, please keep in mind that we want your exercise experience to be as safe as possible. For this reason, we have implemented this policy of requiring physician's clearance that follows the current standards of the American Standards of Sports Medicine.

To Be Completed By the Program Participant:

Patient's Name: _____

Date: _____

Information Requested For: _____

Reason for Requesting Medical Clearance: _____

Physician's Name: _____

Phone #: _____

Email: _____

Address: _____

For Physician Use Only:

I concur with my patient's participation with no restrictions
I concur with my patient's participation in an exercise program if he/she restricts activities to:
_____
_____
I do not concur with my patient's participation in and exercise program

Physician's Name: _____

Physician's Signature: _____

Date: _____

Please Return Completed form to:

The Pilates Movement- PJ Isaac – 900 Linda Lane- Charlotte, NC 28211