



## Personal Training Client Profile Packet

Please complete this form so we can place you with the trainer that best suits your needs. After registering for training, you will be matched with the appropriate trainer and that trainer will call you within 2 business days to schedule your first appointment. Thank you.

Name: \_\_\_\_\_ Age: \_\_\_\_\_

Phone: \_\_\_\_\_ Mobile: \_\_\_\_\_

Email: \_\_\_\_\_

Which option are you registering for? (Please mark one)

☐ **Personal Training Beginner Pack- 4 one-hour sessions** (\$100 for members /\$150 for non-members)

☐ **Partner Training – 5 one-hour sessions** (\$150 members only)

☐ **Group Training (3-6 people) - 5 one-hour sessions** (\$200 members only)

Personal Fitness Goals: \_\_\_\_\_

What days and times of day are best for your Personal Training Sessions?

Is there a particular trainer you would prefer? **Yes** **No** Who? \_\_\_\_\_

**Because of your age or other risk factors, you may be asked to provide a physician's release form.**

In consideration of my participation in the activities of the Owen County Family YMCA, I do hereby agree to hold free from any and all liability the YMCA and its respective officers, employees, and members and do hereby for myself, my heirs, executors, and administrators, waive, release, and forever discharge any and all rights and claims for damages which I may have or which may hereafter accrue to me arising out of or connected with my participation in any of the activities of the YMCA. I also agree that before I use any equipment at the YMCA, it is my responsibility to learn the proper use of the equipment and facilities from the YMCA staff. I understand my privilege to use the YMCA equipment may be withdrawn if, in the sole judgment of the YMCA staff, my use of the equipment or facilities shall be deemed unsafe or in violation of the rules of use. I also agree that as a member or participant, I bear the sole risk of injury resulting from the use of any equipment, the facilities, and class participation. I hereby do declare myself to be physically sound, having medical approval to participate in the activities of the Owen County Family YMCA.

My signature states that I have read and understand this liability release.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Parent/Guardian Signature : \_\_\_\_\_

Date: \_\_\_\_\_

# Owen County Family YMCA

## Health History Participant Information Form

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Email: \_\_\_\_\_

Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

### Circle the programs in which you plan to participate.

|                |                           |               |        |                   |
|----------------|---------------------------|---------------|--------|-------------------|
| Aquatics       | Active Older Adult Cardio | Land Aerobics | Sports | Strength Training |
| Water Aerobics | Yoga                      | Self-defense  | Zumba  | Cardio Machines   |

### Personal History

Check and record the date of occurrence if you have ever had the following.

|                                    |       |                                 |       |
|------------------------------------|-------|---------------------------------|-------|
| Heart problems                     | _____ | High blood pressure             | _____ |
| Difficulty with physical exercise  | _____ | Chronic illness                 | _____ |
| Physician's advice not to exercise | _____ | Muscle, joint, or back disorder | _____ |
| Recent surgery                     | _____ | Lung problems                   | _____ |
| Diabetes                           | _____ | High Cholesterol                | _____ |
| Arterial disease                   | _____ | Respiratory problems            | _____ |
| Asthma                             | _____ | Shortness of breath             | _____ |
| Dizziness                          | _____ | Chest pain                      | _____ |
| Anorexia/Bulimia                   | _____ | Epilepsy                        | _____ |
| Stroke                             | _____ | TIA                             | _____ |
| Hypoglycemia                       | _____ | Back pain                       | _____ |
| Fainting Episodes                  | _____ | Visual impairment               | _____ |
| Hearing impairment                 | _____ | Currently pregnant (due date)   | _____ |
| Arthritis                          | _____ | Joint Replacement               | _____ |

Do you smoke? \_\_\_\_\_ Would you be interested in help with smoking cessation? \_\_\_\_\_

Is your occupation sedentary, active, or heavy lifting? \_\_\_\_\_

Do you believe that you should lose weight? Yes No How much? \_\_\_\_\_

How many times per week do you engage in aerobic activity currently? \_\_\_\_\_

What types of aerobic activity do you enjoy? \_\_\_\_\_