CHEETAH GYM ANDERSONVILLE

REQUEST FOR TRAINING

Service Request (check one):
___TFP $139 – Total Fitness Package: 3 personal training sessions; including fitness evaluation, body composition assessment, nutrition consultation, and training, dependent on trainer's discretion.
___PIP $149 – Perinatal Introductory Package: 2 private sessions with perinatal specialist, nutrition consultation, and diastasis assessment.
___Other (Independent Trainer) _____

Name: _____Date_____

Phone: AM_____ Phone: PM _____

Email address: _____

Trainer preference: Male ___ Female___ Specific Trainer (names) 1._____ 2. _____

I consider myself as a: Beginner_____ Intermediate_____ Advanced_____

Physical restrictions: _____
_____

Goals and objectives: _____
_____

Days and times available: _____

TERMS OF AGREEMENT
1. Limit 1 Total Fitness Package per member.
2. Payment for all sessions must be made in advance. Training sessions are non refundable and non-transferable.
All TFP, TPP and PIP sessions expire 60 days from purchase date.
3. A 24-hour cancellation notice is required from either side. (a) Without proper notice, client will be responsible for payment of missed session. (b) Without proper notice, trainer will provide an additional complimentary session.
4. A "session" is defined by the outline and volume of a workout being completed within the time allotted (55 minutes). This does not necessarily mean that it will take the full time, but that the workout is completed.
5. It is the client's responsibility to obtain physician authorization to conduct a strenuous exercise program. Client warrants that she/he is in good physical condition and may exercise without threat to his/her health.
6. ***TFP expires 60 days*** from date of purchase, all other training packages expire 1 year from purchase date.

Client Signature_____ Date_____

For Front Desk Use Only (This portion must be filled out completely)
Payment Amount_____ Payment Method: Cash Check Visa MC Amex Discover
Sales Receipt Number _____ Sales Person _____
For Office Use Only
Trainer_____ Contacted __/__/__ Manager_____

Informed Consent for Personal Training

1. Explanation of the session- The exercise session you will become involved in will follow progressive exercise levels and will be regulated by your personal trainer. The session may consist of aerobic type activities (rhythmical exercises which utilize large muscle groups for sustained periods of time) such as jogging, cycling, aerobic classes, as well as other similar activities. These exercise activities are designed to place a gradually increasing workload on the body and thereby improve its functioning although no guarantee of improvement can be made. During the exercise sessions you may experience local muscular soreness and fatigue. These minor discomforts may appear in the early stages of the program. However, as the conditioning process continues with regular attendance in the exercise sessions, they should disappear. (Initial _____)

2. Risk and discomforts of the exercise session- The reaction of the cardiovascular system to such activities cannot always be predicted with complete accuracy. Therefore, there is the risk of certain changes occurring during or following the exercises. These changes include abnormalities of blood pressure or heart rate, and in rare instances, cardiac complications. A physician will not be present during the exercise sessions, however, instruction regarding the signs and symptoms of adverse reactions or responses to exercise will be provided before participating in the exercise session. Should you observe any adverse signs or symptoms, they should be reported and appropriate modifications in the exercise regimen will take place. Every effort will be made to avoid any adverse reactions by the entrance interview, the health history questionnaire and by the observations during the exercise sessions. (Initial _____)

3. Confidentiality- The information based on the observations made during exercise sessions is treated as privileged and confidential. However, it may be used for statistical or scientific purpose with your right to privacy retained. (Initial _____)

4. Inquiries- You may refuse to participate now or stop at any time during the exercise session. It is your decision. Before signing this form please feel free to ask any questions regarding any aspect of this program that may be unclear to you. Take as much time as necessary to think it over and if you wish, you may discuss your participation with your doctor. (Initial_____)

I have read the above and do consent to participate in private training.

_____ _____
Client Signature Date

_____ _____
Trainer Date

TESTING OBJECTIVES:
I understand that the tests that are about to be administered to me are for the purpose of determining my physical fitness status, including heart, lung, and blood vessel capacities for whole body activity, body composition (ratio of body fat to muscle, bone, and water), muscular endurance and strength, and joint flexibility.

EXPLANATION OF PROCEDURES: I understand that the tests, which I will undergo, will be performed on a treadmill, bicycle, or steps. The tests are designed to increase the demand on the heart, lung, and blood vessel system. This increase in effort will continue to exhaustion or other symptoms prohibit further exercise. During the test, heart rate, and blood pressure will be periodically measured. Body composition will be determined through use of skin folds to determine levels of body fat versus fat-free weight. Muscular endurance and strength will be determined through the use of body calisthenics and/ or equipment. The sit-and-reach test will be used to determine the flexibility of the hip joint.

DESCRIPTION OF POTENTIAL RISKS: I understand that there exists the possibility that certain abnormal changes may occur during the testing. These changes could include abnormal heart beats, abnormal blood pressure response, various muscle and joint strains or injuries, and in rare instances, heart attack. Professional care throughout the entire testing process should provide appropriate precaution against such problems.

BENEFITS TO BE EXPECTED: I understand that the results of these tests will aid in determining my physical fitness status, and in determining potential health hazards. These results will facilitate a better individualized exercise prescription.

I have read the foregoing information and understand it. Questions concerning these procedures have been answered to my satisfaction. I also understand that I am free to deny answering any questions during the evaluation process, or to withdraw consent and discontinue participating in any procedures. I have also been informed that the information derived from these tests is confidential and will not be disclosed to anyone other than my physician or others who are involved in my care or exercise prescription without my permission. However, I am in agreement that information from these tests not identifiable to me can be used for research purposes.

Participant Signature _____ Date _____

Witness Signature _____ Date _____

Name _____

Today's date ____/____/____

Birth Date ____/____/_____

I identify my gender as: Male____Female____Trans____(fill in the blank)_____

Information about your health risk factors. Please circle all information that applies to your health status.

Y/N Medically diagnosed with hypertension or currently taking medication for high blood pressure?
Average resting blood pressure? _____/_____
Y/N Medically diagnosed with high cholesterol/ triglycerides or currently taking medication for blood lipid levels?
Most recent tested values? _____
Y/N Family history of heart attack, blocked coronary arteries, heart surgery, other heart conditions or cerebral stroke in parents or siblings before the age of 60?
Y/N Do you now or have you used cigarettes or any other tobacco product on a regular basis?
Y/N Is your lifestyle sedentary with very little or no physical activity?
Y/N Are you a male over the age of 45 or female over the age of 55?

Information about your medical history. Please circle all information that applies to your health status.

Y/N Medically diagnosed with or taking medications for diabetes? Please specify _____
Y/N Medically diagnosed with or taking medication for asthma? Please specify _____
Y/N Do you have mitral valve prolapse and take medications before dental procedures?
Y/N Are you over the age of 65 and not accustomed to regular physical activity?
Y/N Do you ever experience dizziness or light-headedness that has resulted in a fall or loss of consciousness?
Y/N Are you currently pregnant or have you given birth within the last 8 weeks?
If pregnant now or in the future I will submit a physician release form to exercise _____*(Signature)*
Y/N Have you had an exercise stress test within the last year? *Please specify* _____
Y/N Do you have a history of a heart condition?
__ Abnormal EKG __ Heart surgery __Blocked coronary arteries __Heart failure __ Congenital heart defect
__ Pacemaker __ Heart attack __ Bypass surgery or angioplasty
__ Other heart defect *Please specify* _____
Y/N Do you experience angina (heart pain or sensations of pain, burning, discomfort, or tightness in your chest, radiating into your arm, jaw, neck, or back)?
Y/N Do you have a history of stroke, peripheral vascular disease, claudicating or recurrent bilateral ankle swelling?
Y/N Do you **frequently** experience heart palpitations, skipped heart beats, or "*racing out of control*" heart rhythms?
Y/N Do you have chronic lung disease or unusual shortness of breath with normal activities? *(Other than asthma)*
Y/N Through your own experience or by a physician's recommendation are you aware of any reason to have medical supervision present when you exercise or to restrict your exercise activity?
Please specify _____

Please list all medications that you are taking and why:

1._____
2._____
3. _____
4. _____
Y/N Do you have any medical concern, limitation, or situation which should be addressed before participating in an exercise program? *Please specify*: _____
_____
Y/N Any hospitalizations, injuries, or illnesses that have caused you to miss work or limit your activity? *Please specify:*
_____
Y/N Allergies? *Please specify:* _____

Physical Activity & Stress:

What is your current physical activity level Please describe your personal behavior characteristics.

___ No physical activity
___ 30 – 60 minutes per week
___ 60 – 120 minutes per week
___ over 180 minutes per week

___ No stress, always easy going
___ Occasional stress, easy going
___ Frequent, moderate stress
___ Constant high stress, driven and never relaxes

Past history of exercise:

Y/N Are you currently involved in an exercise program? *Please specify:*

_____

In the past, what type of exercises have you participated in?

_____

_____

Physician information:

Primary Physician _____
Hospital _____ Telephone _____
Specialist Physician _____
Hospital _____ Telephone _____

Fitness Goals: Please rate your top five fitness goals, "1" being your highest priority.

___ Improve strength
___ Improve flexibility
___ Improve cardiovascular endurance
___ Decrease body fat
___ Gain muscle mass
___ Weight management
___ Reduce stress
___ Learn proper nutritional habits
___ Improve posture

___ Improve cardiovascular health
___ Injury prevention
___ Injury rehabilitation
___ Reduce pain
___ Increase energy
___ Increase muscle tone
___ Improve sports performance
___ Increase flexibility
___ Other _____

Reviewed by _____ Date _____

ADDITIONAL FORM TO BE FILLED OUT FOR PRE-/POST-NATAL TRAINING.