



## PERSONAL TRAINING SERVICES NEW CLIENT REGISTRATION FORM

### ACSM HEALTH STATUS & HEALTH HISTORY QUESTIONNAIRE

This form includes several questions regarding your physical health – please answer every question as accurately as possible. Please ask us if you have any questions. Your responses will be treated in a confidential manner.

#### PERSONAL INFORMATION

Today's Date: \_\_\_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Gender: F M

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

Ethnicity:  American Indian/Alaska native  Asian  Black or African-American (*check all that apply*)   
Caucasian/European  Hispanic/Latino  Native Hawaiian/Pacific Islander

Date of Birth \_\_\_/\_\_\_/\_\_\_ Age \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Emergency \_\_\_\_\_ Contact: \_\_\_\_\_

Physician's Name and Phone: \_\_\_\_\_

#### YES NO (ACSM HEALTH SCREEN)

- Do you have any personal history of heart disease (coronary or atherosclerotic disease)?
- Any personal history of diabetes or other metabolic disease (thyroid,renal,liver)?
- Any personal history of pulmonary disease, asthma, interstitial lung disease or cystic fibrosis?
- Have you experienced pain or discomfort in your chest apparently due to blood flow deficiency?
- Any unaccustomed shortness of breath (perhaps during light exercise)?

- Have you had any problems with dizziness or fainting?
- Do you have difficulty breathing while standing or sudden breathing problems at night?
- Have you experienced a rapid throbbing or fluttering of the heart?
- Do you suffer from ankle edema (swelling of the ankles)?
- Have you experienced severe pain in leg muscles during walking?
- Do you have a known heart murmur?
- Has your serum cholesterol been measured at greater than 200 mg/dl?
- Are you a cigarette smoker?
- Has your HDL (the "good" cholesterol) been measured at greater than 60 mg/dl?
- Would you characterize your lifestyle as "sedentary"?
- Have you had a high fasting blood glucose level on 2 or more occasions ( $\geq 110$ mg/dl)?
- Are you 20% or more overweight or have you been told your "BMI" was greater than 30?
- Have you been assessed as hypertensive on at least 2 occasions (systolic  $> 140$ mmHg or diastolic  $> 90$ mmHg)?
- Do you have any family history of cardiac or pulmonary disease prior to age 55?

## MEDICAL HISTORY

- Are you currently being treated for high blood pressure?  
If you know your average blood pressure, please enter: \_\_\_\_\_  
/

Please check all conditions or diagnoses that apply:

- Abnormal EKG?
- Limited Range of Motion?
- Stroke?

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Abnormal Chest X-Ray? | <input type="checkbox"/> Arthritis?                 | <input type="checkbox"/> Do You Suffer from Epilepsy or Seizures? |
| <input type="checkbox"/> Rheumatic Fever?      | <input type="checkbox"/> Bursitis?                  | <input type="checkbox"/> Chronic Headaches or Migraines?          |
| <input type="checkbox"/> Low Blood Pressure?   | <input type="checkbox"/> Swollen or Painful Joints? | <input type="checkbox"/> Persistent Fatigue?                      |
| <input type="checkbox"/> Asthma?               | <input type="checkbox"/> Foot Problems?             | <input type="checkbox"/> Stomach Problems?                        |
| <input type="checkbox"/> Bronchitis?           | <input type="checkbox"/> Knee Problems?             | <input type="checkbox"/> Hernia?                                  |
| <input type="checkbox"/> Emphysema?            | <input type="checkbox"/> Back Problems?             | <input type="checkbox"/> Anemia?                                  |
| <input type="checkbox"/> Other Lung Problems?  | <input type="checkbox"/> Shoulder Problems?         | <input type="checkbox"/> Are You Pregnant?                        |
|  | <input type="checkbox"/> Recently Broken Bones?     |   |

Has a doctor imposed any activity restrictions? If so, please describe:

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## FAMILY HISTORY

Have your mother, father, or siblings suffered from (please select all that apply):

- |  |   |
|--|---|
| <input type="checkbox"/> Heart attack or surgery prior to age 55.                  | <input type="checkbox"/> High cholesterol |
| <input type="checkbox"/> Stroke prior to age 50.                                   | <input type="checkbox"/> Diabetes         |
| <input type="checkbox"/> Congenital heart disease or left ventricular hypertrophy. | <input type="checkbox"/> Obesity          |
| <input type="checkbox"/> Hypertension  | <input type="checkbox"/> Asthma           |
| <input type="checkbox"/> Leukemia or cancer prior to age 60.                       | <input type="checkbox"/> Osteoporosis     |

## MEDICATIONS

Please Select Any Medications You Are Currently Using:

<input type="checkbox"/> Diuretics	<input type="checkbox"/> Other Cardiovascular
<input type="checkbox"/> Beta Blockers	<input type="checkbox"/> NSAIDS/Anti-inflammatories (Motrin, Advil)
<input type="checkbox"/> Vasodilators	<input type="checkbox"/> Cholesterol
<input type="checkbox"/> Alpha Blockers	<input type="checkbox"/> Diabetes/Insulin
<input type="checkbox"/> Calcium Channel Blockers	<input type="checkbox"/> Other Drugs (record below).

Please list the specific medications that you currently take:

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## LIFESTYLE

Are you a cigarette smoker? If so, how many per day?

Previously a cigarette smoker? If so, when did you quit?

How many years have you smoked or did you smoke before quitting? \_\_\_\_\_

Do you/did you smoke (Circle one): Cigarettes    Cigars    Pipe

Please Rate Your Daily Stress Levels (select one):

Low                     
 Moderate           
 High but I enjoy the   
 High: sometimes           
 High: often difficult to challenge   
 High: difficult to handle           
 High: difficult to handle.

### Alcohol Units Table

Do you drink alcoholic beverages?

Type of Drink	Units
½ pint of beer	1
1 glass of wine	1
1 pub measure of spirits (Gin, Vodka etc.)	1
1 can of beer	1.5
1 bottle of strong lager	2.5
1 can of strong lager	4
1 bottle of wine	7
1 litre bottle of wine	10
1 bottle of fortified wine (port, sherry etc.)	14
1 bottle of spirits	30

Dietary Habits. Please Select All That Apply.

I seldom consume red or high-fat meats.

I eat at least 5 servings of fruits/vegetables per day.

I pursue a low-fat diet.

I almost always eat a full, healthy breakfast.

My diet includes many high-fiber foods.

I rarely eat high-sugar or high-fat desserts.

How many units of alcohol do you consume per week: (see



Please indicate any other medical conditions or activity restrictions that you may have, or any other information you feel is critical to understanding your readiness for exercise. It is important that this information be as accurate and complete as possible

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Please indicate your personal health and fitness-related goals (select all that apply):

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Cardiovascular Fitness | <input type="checkbox"/> Injury Rehab                     | <input type="checkbox"/> Muscular Strength       |
| <input type="checkbox"/> Feel Better            | <input type="checkbox"/> Look Better                      | <input type="checkbox"/> Reduce Stress           |
| <input type="checkbox"/> General Fitness        | <input type="checkbox"/> Lose Weight                      | <input type="checkbox"/> Reduce Back Pain        |
| <input type="checkbox"/> Improve Diet           | <input type="checkbox"/> Lower Cholesterol/Blood Pressure | <input type="checkbox"/> Sport-Specific Training |
| <input type="checkbox"/> Improve Flexibility    | <input type="checkbox"/> Muscular Size                    | <input type="checkbox"/> Stop Smoking            |

Please tell us a little about your exercise patterns and goals:

What is your exercise history?

What health improvements do you need?

What are your activity preferences?

What barriers to success do you anticipate?

How will you know that you are succeeding?

What is your *motivation* level?

High       Medium       Low

What is your *confidence* level?

High       Medium       Low

Please use the space below to record three specific commitments that you are willing to make to your own health and fitness goals. For example, you might commit “to arrive, ready for exercise, on Mondays, Wednesdays, and Fridays by 6:30p.m.” Your commitments should be challenging, but also realistic and attainable. When finished, please sign this form to signify your personal commitment.

Commitment #1:

Commitment #2:

Commitment #3:

Printed Name

Signature

Date

**CANCELLATION NOTICE**

24 hour notice is required for session cancellation.

We reserve the right to charge for appointments cancelled or broken without 24 hours advance notice.

**LATE POLICY**

If a client is late for a session, it will still end one hour after the scheduled start time.

**REFUND POLICY**

All packages are nonrefundable, nontransferable, and expire one year from initial date of use.

**I have carefully read and understand the above information. The policies have been explained to me by the Campus Recreation staff and any questions have been answered to my satisfaction.**

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

**Date:**