



**THE ALASKA CLUB**

**The Alaska Club Personal Training Information Packet**

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
E-mail: \_\_\_\_\_ Cell Number: \_\_\_\_\_  
Day Phone: \_\_\_\_\_ Evening Phone: \_\_\_\_\_  
Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Gender: Male / Female Height: \_\_\_\_\_ Weight: \_\_\_\_\_  
In case of emergency contact: \_\_\_\_\_ Phone: \_\_\_\_\_  
Name of Physician: \_\_\_\_\_ Physician Address: \_\_\_\_\_  
Physician Phone: \_\_\_\_\_ Date and reason last consulted: \_\_\_\_\_

**Payments, Rescheduling, Interruption of Services, Refunds, and Expiration:**

- All payments of services shall be made to The Alaska Club prior to receiving training sessions.
- Rescheduling of any session requires a minimum of 24 hour direct notice to the Trainer to avoid being charged a "No Show" session.
- Interruption of service requires a written request submitted to the Trainer stating the reason for interruption and the anticipated continuation date.
- Client agrees to arrive promptly for the scheduled sessions and agrees to shorten the session if tardy.
- Unused training sessions are refundable for medical reasons only. Those requests should be made directly to The Alaska Club's Personal Training Department.
- Sessions are transferable between other Alaska Club Trainers and with other family members on the same account.
- Partner or multiple training clients acknowledge that if one or more of the training partners are absent from a training session that the session will be forfeited and the client that is present will receive the training.
- All training packages expire 9 months from the date of purchase.
- Clients will not distribute any of the written material provided by the Trainer to other individuals without written permission from the Trainer.

**Guarantee of Services:**

- Should my Alaska Club Trainer not appear for a prescheduled, prepaid session, I have the option of rescheduling the missed appointment or receive a full refund for that particular session.
- The Alaska Club urges all participants to obtain a medical clearance from their physician prior to beginning any exercise program.
- Any Trainer may insist upon medical clearance before any training occurs.
- All client information and discussions will be held in absolute confidence between the Trainer and the client.

Has your Physician ever advised you against exercising? Yes / No  
If yes, please explain:

Do you now have or have you ever experienced or been diagnosed with any of the following:

Chest Pains	yes / no	Daily Coughing	yes / no
Chest Pressure	yes / no	Fainting	yes / no
Palpitations/ skipped beats	yes / no	Seizures	yes / no
Unexplained weight change	yes / no	Difficulty walking	yes / no
Numbness or tingling	yes / no	Allergies	yes / no
Stumbling	yes / no	Excessive shortness of breath	yes / no
Frequent headaches	yes / no	Dizziness	yes / no
Increased blood pressure	yes / no	Increased blood cholesterol	yes / no
Diabetes or thyroid condition	yes / no	Tobacco usage	yes / no
Pregnancy (now or within the last 3 months)	yes / no	Back Pain	yes / no
Anemia	yes / no	Arthritis	yes / no
Angina	yes / no	Heart Attack	yes / no
Liver Disease	yes / no	Osteoporosis	yes / no
Cancer	yes / no	Hypertension	yes / no
Hernia	yes / no	Hypoglycemia	yes / no
Eating Disorder	yes / no	Joint Problem	yes / no
Obesity (more than 20% over ideal body weight)	yes / no	Post menopausal	yes / no
Difficulty with physical exercise	yes / no	Circulatory problems	yes / no
Emphysema	yes / no	Chronic Bronchitis	yes / no
Asthma	yes / no	Neurological problems	yes / no

Condition(s) not listed: \_\_\_\_\_

In general, would you say your health is: (circle one)

Excellent

Very Good

Good

Fair

Poor

Please note, if you checked one or more of the above questions "yes", it is recommended that you consult a physician before beginning an exercise program. If you choose not to see a physician, please sign:

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

NOTE: \*If your medical history changes in any way, it is your responsibility to notify your Trainer. If you are taking any medications, you should consult with your physician to see how these medications might interfere with safe participation in this or any exercise program.

Are you presently under a physician's care for any of the above or for any other condition? Yes / No  
If "yes", please provide the type of treatment you are receiving and your physician's name and address:

May I call him/her regarding your condition and treatment? Yes / No

Have you had any major illnesses and/or surgeries? Yes / No  
If yes, please explain:

Do you have any current medical problems or incompletely healed injuries? Yes / No  
If yes, please explain:

Are you presently receiving physical therapy? Yes / No  
If yes, please explain:

Please provide your therapist's name, address, and phone number:

May I call him/her regarding your condition and treatment? Yes / No

Are you presently physically active? Yes / No

If yes, what activities do you currently participate in? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How often and at what intensity do you participate in them? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What type of work do you do (occupation)? \_\_\_\_\_

Do you have any children? Yes / No If yes, how many? \_\_\_\_\_ What are their ages? \_\_\_\_\_

How do you spend your day?

\_\_\_\_\_ Sitting          \_\_\_\_\_ Lifting          \_\_\_\_\_ Walking          \_\_\_\_\_ Climbing stairs

Rate the amount of physical activity you perform while at work:

Very little          Little -Moderate          Active          Very Active

What time of the day do you prefer to exercise? \_\_\_\_\_

What type of exercises appeal to you? (Check all that apply)

\_\_\_\_\_ Walking/Hiking    \_\_\_\_\_ Jogging/ Running    \_\_\_\_\_ Swimming    \_\_\_\_\_ Cycling  
\_\_\_\_\_ Climbing    \_\_\_\_\_ Rowing    \_\_\_\_\_ Stretch/Yoga    \_\_\_\_\_ Plyometrics  
\_\_\_\_\_ Group Fitness Classes    \_\_\_\_\_ Resistance/Strength Training

Outdoor Activities like: \_\_\_\_\_

Sports like: \_\_\_\_\_

Areas I want to improve:

\_\_\_\_\_ aerobic endurance    \_\_\_\_\_ muscular endurance    \_\_\_\_\_ muscular strength  
\_\_\_\_\_ flexibility    \_\_\_\_\_ reflexes    \_\_\_\_\_ power  
\_\_\_\_\_ physique    \_\_\_\_\_ coordination    \_\_\_\_\_ balance  
\_\_\_\_\_ self esteem    \_\_\_\_\_ eating habits    \_\_\_\_\_ sleep better more \_\_\_less \_\_\_  
\_\_\_\_\_ speed/agility    \_\_\_\_\_ posture    \_\_\_\_\_ other: \_\_\_\_\_

Do you drink alcohol? Yes / no

If yes, how often do you drink (times/week)?

Do you drink coffee, tea, soft drinks or other types of beverages containing caffeine? Yes / No

If yes, what type of beverage, how much and how often:

Describe your current diet:

Breakfast: \_\_\_\_\_

Snack: \_\_\_\_\_

Lunch: \_\_\_\_\_

Snack: \_\_\_\_\_

Dinner: \_\_\_\_\_

Snack: \_\_\_\_\_

Number of glasses of water consumed daily: \_\_\_\_\_

Do you take any supplements? Yes / No  
If yes, please explain:

Do you experience stress? Yes / No  
If yes, when do you experience stress?

Self Assessment: On a scale of 1-10 with 10 being very high, how would you rate the following?

	1	2	3	4	5	6	7	8	9	10
Physical Strength										
Physical Endurance										
Aerobic/ Cardio Endurance										
Flexibility										
Overall Health										
Nutritional Habits										
Physical Appearance										
Body Composition (Lean muscle vs. body fat)										
Agility, Balance, Coordination										

What is your greatest barrier to exercise? (Circle all that apply)

\_\_\_ Procrastination

\_\_\_ Poor eating habits

\_\_\_ Low or no energy

\_\_\_ Lack of confidence in exercise atmosphere

\_\_\_ Lack of friend/family support

\_\_\_ Over-scheduling /too many commitments

\_\_\_ Weight (not happy with your physique)

\_\_\_ Lack of motivation

\_\_\_ Not familiar with exercise procedures or equipment

\_\_\_ Do not like exercising

\_\_\_ Other:



# Physician Medical Release Form

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

Dear Doctor:

Your patient, \_\_\_\_\_, wishes to start a personalized training program. The activity will involve the following: (please include type, frequency, duration and intensity of activities)

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If your Patient is taking medications that will affect his or her heart rate response to exercise, please indicate the manner of the effect (raises, lowers, or has no effect on heart rate response):

Type of medication: \_\_\_\_\_

Effect: \_\_\_\_\_

Please identify any recommendations or restrictions that are appropriate for your patient in this exercise program:

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Thank you,

*The Alaska Club Personal Training Department*

**For Physician's use** Please sign and fax to: (907)337-5865, Attention: Personal Training Department Director

\_\_\_\_\_ has my approval to begin an exercise program with the recommendations or restrictions stated above.

Signed \_\_\_\_\_ Date \_\_\_\_\_ Phone \_\_\_\_\_

Physician's Signature