

JRC/The Alaska Club Personal Training Information Packet

Name: _____ Trainer: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Email: _____ Cell Phone: _____

Day Phone: _____ Evening Phone: _____

Age: _____ Date of Birth: _____ Gender: Male / Female Height: _____ Weight: _____

Emergency contact: _____ Phone: _____

Relationship: _____

Name of Physician: _____ Physician Address: _____

Physician Phone: _____ Date and reason last consulted: _____

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/Angina.....yes / no
Chest Pressure.....yes / no
Palpitations/ skipped beats.....yes / no
Unexplained weight changeyes / no
Numbness or tingling...Where?.....yes / no
Stumbling.....yes / no
Frequent headaches.....yes / no
Increased blood pressure.....yes / no
Thyroid conditionyes / no
Pregnancy (now or within the last 3 months).....yes / no
Anemia.....yes / no
Stroke.....yes / no
Liver Disease/Transplant.....yes / no
Cancer.....yes / no
Hernia...Type _____.....yes / no
Eating Disorder.....yes / no
Obesity (more than 20% over ideal body weight).....yes / no
Difficulty with physical exercise.....yes / no
Emphysema.....yes / no
Asthma.....yes / no
Diabetes/Pre-Diabetes.....yes / no
Fibromyalgia.....yes / no

Daily Coughing.....yes / no
Fainting.....yes / no
Seizures/Epilepsy.....yes / no
Difficulty walking.....yes / no
Allergiesyes / no
Excessive shortness of breath.....yes / no
Dizzinessyes / no
Increased blood cholesterolyes / no
Tobacco use.....yes / no
Back Pain.....yes / no
Arthritis.....yes / no
Heart Attack.....yes / no
Osteoporosis/Osteopenia.....yes / no
Hypertension.....yes / no
Hypoglycemia.....yes / no
Joint Problem.....yes / no
Post menopausal.....yes / no
Circulatory problems.....yes / no
Chronic Bronchitis.....yes / no
Neurological problems.....yes / no
Heart Disease.....yes / no

Condition(s) not listed: _____

Explanation of above if needed: _____

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 are your activities?

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? _____

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 _____ Martial Arts _____ Resistance/Strength Training

Outdoor Activities: _____

Sports: _____

Other: _____

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 many drinks/week)? (1 drink = 12 oz beer/6 oz wine/1 oz hard liquor)

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 physician prescribed medications? Yes / No If yes, please list: _____

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

Do you experience stress? Yes / No
If yes, when do you experience stress and to what degree?

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 Fitness										
Flexibility										
Overall Health										
Nutritional Habits										
Physical Appearance										
Body Composition (Lean muscle vs. body fat)										

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

- Lack of time Lack of motivation Lack of confidence in exercise atmosphere
 Low or no energy Poor eating habits Do not like exercising
 Weight (not happy with your physique) Lack of friend/family support

___ Not familiar with exercise procedures or equipment ___ other: _____

Please use the space below to make any other comments:

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

- All payments of services shall be made to JRC/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 JRC/The Alaska Club’s Personal Training Department.
- Sessions are transferable between other JRC/Alaska Club Trainers.
- All training packages **expire 6 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 JRC/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.
- JRC/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.