



## **Personal Training Initial Packet**

**\*\*\*\*Please complete and return to the reception desk at least 2 days prior to your scheduled Fitness Assessment\*\*\*\***

**Name:** \_\_\_\_\_ **D.O.B:** \_\_\_\_\_ **Today's Date:** \_\_\_\_\_

**Member      or      Non-member**  
(circle one)

**Please provide the best phone and email we can reach you at.**

**Phone:** (      ) \_\_\_\_\_ **Email:** \_\_\_\_\_

**Other Information:** (Please feel free to add any notes/comments/questions)

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**\*\*\*IMPORTANT: If you checked any of the boxes in Section 1 or 2 of the PASQ (next page) you need to obtain medical clearance from your primary care physician before the fitness assessment.\*\*\***

**Office use:**

**Date of Scheduled Fitness Assessment:** \_\_\_\_\_ **Time:** \_\_\_\_\_

**Trainer:** \_\_\_\_\_

**PT Package Purchased:** 1 3 5 8 12 20  
Have not purchased  
(circle one)

**Place packet in assigned trainer's file.**

## Pre-Activity Screening Questionnaire (PASQ) – Self-Guided

### **Instructions:**

Please complete and sign this form, and then refer to the Summary/Recommendations.

### **Current Physical Activity**

Over the last three months, have you regularly performed physical activity for at least 30 minutes, three days/week at a moderate intensity level?

**Note:** Moderate intensity activity causes noticeable increases in heart rate and breathing such as walking at a brisk pace

Yes

No

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### **Section 1 – Medical Conditions**

Please check the box (✓) for any of the following medical conditions that you have had or currently have.

- Heart attack
- Heart surgery
- Cardiac catheterization
- Coronary angioplasty (PTCA)
- Heart valve disease
- Heart failure
- Heart transplantation
- Congenital heart disease
- Abnormal heart rhythm
- Pacemaker/implantable cardiac defibrillator
- Peripheral vascular disease (PVD or PAD): disease affecting blood vessels in arms, hands, legs, and feet
- Cerebrovascular disease -- stroke or TIA (transient ischemic attack)
- Renal (kidney) disease
- Type 1 or Type 2 Diabetes


### **Section 2- Signs or Symptoms**

Please check the box (✓) for any of the signs/symptoms that you have recently experienced.


- Pain, discomfort in the chest, neck, jaw or arms at rest or upon exertion
- Shortness of breath at rest or with mild exertion
- Dizziness or loss of consciousness during or shortly after exercise
- Shortness of breath occurring at rest or 2-5 hours after the onset of sleep
- Edema (swelling) in both ankles that is most evident at night or swelling in a limb
- An unpleasant awareness of forceful or rapid beating of the heart
- Pain in the legs or elsewhere while walking; often more severe when walking upstairs/uphill
- Known heart murmur
- Unusual fatigue or shortness of breath with usual activities

**Summary/Recommendations:**

Did you check any of the items in Section 1 or in Section 2?

Yes 

- Medical clearance\* is necessary\*\*\*
- After obtaining medical clearance, begin with exercise light\* to moderate\*\* intensity exercise and/or follow recommendations from healthcare provider

No 

- Medical clearance\* is not necessary
- Begin with light\* to moderate\*\* intensity

+ **Medical Clearance** -- approval from a healthcare professional to engage in physical activity

\***Light Intensity** – an activity that causes slight increases in heart rate and breathing

\*\***Moderate Intensity** -- an activity that causes noticeable increases in heart rate and breathing

**Section 4- Acknowledgement, Follow-Up and Signature**

I acknowledge that I have read this questionnaire in its entirety and have responded accurately, completely, and to the best of my knowledge. Any questions regarding the items on this questionnaire were answered to my satisfaction. Also, if my health status changes at any time such that my answers to any of the above questions would be changed, I understand that I am responsible to inform a staff member at this facility of any such changes.

\_\_\_\_\_ **Print your name here**

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

\_\_\_\_\_ **Date**

\*\*\* **Medical Clearance** -- approval from a healthcare professional to engage in physical activity.

If Medical Clearance is necessary, you are required to provide Campus Recreation with a note from your primary care physician clearing you to exercise before continuing with the program. If you decide not to receive medical clearance you may sign a refusal to obtain medical clearance to exercise form (available from trainer at first session).

Medical Clearance notes/forms maybe:

Faxed to: 207-581-4898

OR

Emailed to: [adrianna.delamo@maine.edu](mailto:adrianna.delamo@maine.edu) AND please indicate who your trainer is.



## Personal Training and Fitness Assessment Informed Consent for Exercise

**Waiver and Assumption of Risk:** I, \_\_\_\_\_, understand that I will be participating in a fitness test that involves physical activity ranging from resting measurements to moderately intense aerobic and resistance exercise. The purpose of this testing is to assess my physical fitness in the following areas:

1. Cardiovascular Fitness – Assessed by a 3-minute step test, treadmill test or walking test around the indoor track.
2. Body Composition (% fat) – Assessed by the measurement of the thickness of skin folds at 3 locations on the body or a bioelectrical impedance analysis.
3. Muscular Strength and Endurance – Assessed by performance on a maximal pushup and sit-up test.
4. Muscular flexibility of the low back and hamstrings – Assessed by sit and reach, toe-touching measurement device.
5. Various other physical fitness tests such as balance, postural analysis, and mobility.

I affirm that I will follow the directions of the tester at all times. I also understand that I may terminate the testing at any time for any reason.

I understand that the benefits of the testing include: 1. Knowledge of my own level of fitness, 2. Understanding of potential risk for future disease, and 3. Scores against which I can compare scores obtained at a later date to track my progress towards a healthier body.

I understand that participation in any form of physical activity has an inherent risk, and may result in injury, disability, and in rare cases, death. In any event, I acknowledge and agree that I assume any and all risks associated with any exercise in which I agree to. It is the trainer's job to minimize any of these risks as much as possible. Mainly, minimizing these risks will be done through preliminary information relating to my health and fitness history as well as close observation during the test. In any case of emergency, trained professionals and equipment are available to handle any extraordinary circumstances.

Furthermore, I hereby forever release and discharge and hereby hold harmless the New Balance Student Recreation and Fitness Center, including the University of Maine, Orono and any of its representatives from any and all claims, demands, damages, rights of action or causes of action, present or future, arising out of or connected with my willing participation in this physical exercise including any resulting injuries.

\_\_\_\_\_  
Participant's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Administered by (trainer's name)

## Exercise History and Attitude Questionnaire

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

*General Instructions:* Please fill out this form as completely as possible. If you have any questions, DO NOT GUESS.

1. Please rate your exercise level on a scale of 1 to 5 (5 indicating very strenuous) for each age range through your present age:

15-20 \_\_\_\_\_ 21-30 \_\_\_\_\_ 31-40 \_\_\_\_\_ 41-50 \_\_\_\_\_ 51+ \_\_\_\_\_

2. Were you a high school and/or college athlete?

Yes No If yes, please specify \_\_\_\_\_

3. Do you have any negative feelings toward, or have you had any bad experience with, physical-activity programs?

Yes No If yes, please explain \_\_\_\_\_

4. Do you have any negative feelings toward, or have you had any bad experience with, fitness testing and evaluation?

Yes No If yes, please explain \_\_\_\_\_

5. Rate yourself on a scale of 1 to 5 (1 indicating the lowest value and 5 the highest).

Circle the number that best applies.

Characterize your present athletic ability. 1 2 3 4 5

When you exercise, how important is competition? 1 2 3 4 5

Characterize your present cardiovascular capacity. 1 2 3 4 5

Characterize your present muscular capacity. 1 2 3 4 5

Characterize your present flexibility capacity. 1 2 3 4 5

6. Do you start exercise programs but then find yourself unable to stick with them? Yes No

7. How much time are you willing to devote to an exercise program? \_\_\_\_\_ mins/day \_\_\_\_\_ days/wk

8. Are you currently involved in regular endurance (cardiovascular) exercise?

Yes No If yes, specify the type of exercise(s) \_\_\_\_\_  
 \_\_\_\_\_ minutes/day \_\_\_\_\_ days/week

Rate your perception of the exertion of your exercise program (circle one):

Light Fairly light Somewhat hard Hard

9. How long have you been exercising regularly? \_\_\_\_\_ months \_\_\_\_\_ years

10. What other exercise, sport, or recreational activities have you participated in?

In the past 6 months? \_\_\_\_\_

In the past 5 years? \_\_\_\_\_

11. What types of exercise interest you?

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Walking           | <input type="checkbox"/> Jogging              | <input type="checkbox"/> Strength training |
| <input type="checkbox"/> Stationary biking | <input type="checkbox"/> Traditional aerobics | <input type="checkbox"/> Racquet sports    |
| <input type="checkbox"/> Stair climbing    | <input type="checkbox"/> Elliptical striding  | <input type="checkbox"/> Yoga/Pilates      |
| <input type="checkbox"/> Cycling           | <input type="checkbox"/> Swimming             | <input type="checkbox"/> Other activities  |

12. Rank your goals in undertaking exercise: What do you want exercise to do for you?

Use the following scale to rate each goal separately.

(1) Not at all important (2) Somewhat important (3) Extremely important

- |  |   |   |   |
|--|---|---|---|
| a. Improve cardiovascular fitness              | 1 | 2 | 3 |
| b. Lose weight/body fat                        | 1 | 2 | 3 |
| c. Reshape or tone my body                     | 1 | 2 | 3 |
| d. Improve performance for a specific sport    | 1 | 2 | 3 |
| e. Improve moods & ability to cope with stress | 1 | 2 | 3 |
| g. Increase strength                           | 1 | 2 | 3 |
| h. Increase energy level                       | 1 | 2 | 3 |
| i. Feel better                                 | 1 | 2 | 3 |
| j. Increase enjoyment                          | 1 | 2 | 3 |
| k. Social interaction                          | 1 | 2 | 3 |
| l. Other                                       | 1 | 2 | 3 |

## **Personal Training Policies**

A Fitness Assessment is required before any Personal Training services may be rendered.

### **PAS-Q & Medical Clearance:**

A PAS-Q Form is required, and a Medical Clearance Form (a note from your physician) is required of all participants who check any of the items in Section 1 or in Section 2 of the PAS-Q. Note: Personal training staff reserve the right to require medical clearance from any client they feel may be at risk.

### **Session Duration:**

All personal training sessions are one hour.

All personal training packages expire 12 months from the date of purchase.

### **Attire:**

Come prepared to each training session in proper workout attire and footwear (shorts, gym pants, T-shirt, sweatshirt, supportive sneakers). Participants arriving unprepared for their training session may result in that session being removed from their training session package.

### **Tardiness Policy:**

Clients are responsible for arriving on time for their training sessions. Trainers are only obligated to wait for a late client until 15 minutes past the scheduled start time. Sessions that start late will still end at the originally-scheduled end time. The session will still be removed from your training session package. Exceptions will only be made in the case of a medical emergency accompanied by a doctor's note.

### **Cancellation Policy:**

Clients are responsible for calling their trainer at least one hour in advance of the scheduled training session if they need to cancel or reschedule a session. Failure to contact your trainer at least one hour in advance or failure to show up for a session will result in that session being removed from your training session package.

Exceptions will only be made in the case of a medical emergency accompanied by a doctor's note.

### **Package Expiration/Refund Policy:**

Individuals registering for personal training must complete all personal training sessions by the expiration date of the training package. All personal training packages expire 12 months from the date of purchase. All packages are non-refundable but *may be transferred to another person before the expiration date. If transferred, services must be used before the expiration date. A client may only receive a refund if accompanied by a doctor's note.*

### **Changing Trainers**

In the event the client wants to change trainers or the trainer no longer works for Campus Recreation they will need to purchase another Fitness Assessment with the new trainer if it has been more than 3



months since their last training session. If it has been less than 3 months since the client's last training session then the client will only need to complete a Returning Client Packet from the front desk before training can begin (no fitness assessment required).

I, \_\_\_\_\_ **understand and agree to the Personal Training Policies.**

**Client's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Parent or Guardian Signature \_\_\_\_\_ **Date:** \_\_\_\_\_  
(If participant under the age of 18 years)





## Medical Clearance to Exercise Form

Your patient \_\_\_\_\_ (Name of Participant) would like to participate in the exercise/fitness programs at the New Balance Student Recreation Center, a **non-clinical health/fitness facility** that provides a variety of exercise/fitness activities. To comply with pre-activity screening recommendations established by the American College of Sports Medicine, we have all participants complete a brief health history questionnaire (PASQ). Based on the responses to the PASQ (copy attached), your patient needs to obtain medical clearance prior to participating in our exercise/fitness programs. Once completed and signed by you, your patient can return this clearance form to me or you can fax it to me at 207-581-4898 (secure fax number of fitness facility). If you have any questions, please feel free to contact me at 207-581-3482 or [caitlin.caserta@maine.edu](mailto:caitlin.caserta@maine.edu).

Program & Instructor's Name: \_\_\_\_\_

Thank you,

Caitlin Caserta, M.Ed-Kinesiology and Physical Education, ACSM EP-C, Assistant Director for Fitness

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### **Please check (√) one of the following:**

Not cleared to exercise at this facility – should be referred to a clinically supervised exercise program

Cleared to exercise at this facility

Please check (√) the highest exercise intensity level your patient is cleared for and provide any other restrictions/limitations

Light (<57 to < 64% HR max)

Moderate (64 to < 76% HR max)

Vigorous (76 to < 96% HR max)

Near Maximal to Maximal ( $\geq$  96% HR max)

Restrictions/Limitations:

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\_\_\_\_\_  
Physician's Name (printed)

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Phone number

\_\_\_\_\_  
Date