GEORGE MASON UNIVERSITY
PERSONAL TRAINING REGISTRATION FORM
NEW CLIENT

PLEASE PRINT, COMPLETE, AND DELIVER THIS FORM TO THE AQUATIC and FITNESS CENTER, RAC, OR SKYLINE FITNESS FRONT DESK:

Ethan Carter
Director of Fitness- Aquatics and Fitness Center
4400 University Dr. MSN 1C6
Fairfax, VA 22030

Name: _____ **Today's Date:** _____

Birth Date: ____/____/____ **Gender:** _____ ☐ **Home** ☐ **Cell** ☐ **Work (Phone):** _____

Email: _____ **Membership Type:** ☐ **Student** ☐ **F/S** ☐ **Alumni** ☐ **Community** ☐ **Other** _____

PLEASE CHECK YOUR PREFFERRED LOCATION FOR PERSONAL TRAINING:

☐ **Aquatic and Fitness Center** ☐ **RAC** ☐ **Skyline Fitness Center**

WHAT TIME OF DAY DO YOU PREFER TO WORK WITH YOUR PERSONAL TRAINER?

Please list all the days and time blocks you are available to meet with a personal trainer. The facilities on the George Mason University-Fairfax campus open as early as 6:00am on weekdays, and personal trainers may meet with clients until as late as 10pm based on availability. Fitness assessment appointments generally last 30 minutes to 1 hour and single PT sessions are 30 minutes to 1 hour.

MONDAY _____ THURSDAY _____

TUESDAY _____ FRIDAY _____

WEDNESDAY _____ WEEKEND _____

I WOULD LIKE TO REQUEST:

☐ A FEMALE TRAINER ☐ A MALE TRAINER ☐ NO PREFERENCE ☐ I REQUEST: _____

*****Payment is Required at the First Meeting with your Personal Trainer*****

Package	Student	Faculty/Staff, Alumni	Community
Consultation/Fitness Assessment	☐ $20	☐ $20	☐ $20
Design Me A Workout	☐ $65	☐ $65	☐ $65
3 Sessions **(30 min)**	☐ $45	☐ $60	☐ $75
Add On Session **(30 min)**	☐ $15	☐ $20	☐ $25
3 Sessions **(60 min)**	☐ $105	☐ $135	☐ $150
6 Sessions **(60 min)**	☐ $180	☐ $240	☐ $270
12 Sessions **(60 min)**	☐ $300	☐ $420	☐ $480
3 Group Sessions **(60 min)**	☐ $75/person	☐ $90/person	☐ $105/person
Group Add On Session **(60 min)**	☐ $25/person	☐ $30/person	☐ $35/person

To be completed by GMU staff only:

Payment Complete ☐ Payment Date:_____/_____/_____ Payment Amount: $_____

GMU Staff Signature:_____

GEORGE MASON UNIVERSITY
HEALTH HISTORY QUESTIONNAIRE (HHQ)

(For People Aged 16 to 69)

Regular physical activity is fun and healthy. More people are starting to become more active every day.

Physical Activity is safe for most people. However, some people should check with their doctor before becoming more physically active. If you are planning to become more physically active than you are now, start by answering the questions in the boxes below.

The Health History Questionnaire will tell you if you should check with your doctor before you start an exercise regimen. If you are over 69 years of age, and you are not used to physical activity, please consult your physician or health care provider.

Please read the questions carefully and answer each one honestly.

Emergency Contact Information

Relationship to Emergency Contact: _____
Emergency Contact Name:_____
Phone: _____ Street Address: _____
City, State, Zip: _____ E-mail: _____

YOUR Clinic/Physician: _____ Clinic/Physician Phone: _____

PLEASE PLACE A CHECK NEXT TO ALL TRUE STATEMENTS REGARDING PERSONAL MEDICAL HISTORY

CARDIOVASCULAR RISK FACTORS

___ I am a man older than 45 years of age
___ I am a woman older than 55 years of age, have had a hysterectomy, or am menopausal
___ I smoke, or quit smoking within the past 6 months
___ My blood pressure is > 140 / 90 mmHg
___ I take blood pressure medication
___ I do not know my blood pressure
___ My blood cholesterol level is > 200 mg / dL
___ I do not know my cholesterol level
___ I have a close blood relative who had a heart attack or heart surgery before age 55 (father or brother) or age 65 (mother or sister)
___ I am physically inactive - less than 30 minutes of physical activity at least 3 days per week
___ I am more than 20 pounds overweight

If you marked two or more statements in the "Cardiovascular Risk Factors" section
You will need to consult with your physician or qualified health care provider prior to engaging in exercise.

- Your doctor will provide guidelines regarding activities in which it is safe to participate.

HISTORY

___ I have had a heart attack
___ I have had heart surgery
___ I have had cardiac catheterization
___ I have had coronary angioplasty (PTCA)
___ I have a pacemaker / implantable cardiac device
___ I have had a defibrillator / rhythm disturbance
___ I have heart valve disease
___ I have had heart failure
___ I had a heart transplant
___ I have congenital heart disease

If you marked two or more statements in the "History" section

You will need to consult with your physician or qualified health care provider prior to engaging in exercise.

- Your doctor will provide guidelines regarding activities in which it is safe to participate.

SYMPTOMS

___ I experience chest discomfort with exertion
___ I experience unreasonable breathlessness
___ I experience dizziness, fainting or blackouts
___ I take heart medications

OTHER HEALTH ISSUES

___ I have diabetes
___ I have asthma or other lung disease
___ I have burning or cramping sensations in my lower legs when walking short distances
___ I have musculoskeletal problems that limit my physical activity
___ I have concerns about the safety of exercise
___ I take one, or more prescription medications
___ I am pregnant
___ None of the above

FAMILY MEDICAL HISTORY

Please indicate all that apply to your mother, father or siblings:

___ cardiovascular disease ___ stroke
___ pulmonary disease ___ sudden death
___ metabolic disease

PERSONAL MEDICATIONS

Please list specific prescription medications that you are currently taking. Include vitamins, supplements, herbs, over-the-counter remedies, etc.

_____
_____

DIETARY HABITS

Please indicate all that apply:

___ frequently consume red or high-fat meats ___ eat 5 servings of fruits/vegetable a day
___ pursue low-fat diet ___ almost always eat a healthy breakfast
___ include many high-fiber foods in daily diet ___ rarely eat high-sugar or -fat desserts
___ consume at least 8 cups of fluid per day ___ consciously monitor portion sizes
___ eat at restaurants/fast food 3+ times/week ___ drink one or more cans of soda a day

What is your approximate water intake per day? _____

Circle how closely you monitor your dietary habits:

1 2 3 4 5 6 7 8 9 10

not at all moderately extreme
"I eat what I want" "I am conscious of what I eat" "I closely monitor everything"

LIFESTYLE

Are you a smoker? ____ How many a day? _____ How long have you smoked? _____
If you smoked in the past, how long has it been since you quit? _____
Please indicate your daily stress level
___ low ___ moderate
___ high (I enjoy the challenge) ___ high (sometimes difficult to handle)
___ high (often too difficult to handle)

CURRENT PHYSICAL ACTIVITY

On average, how many times do you exercise per week? _____
On average, how long do you exercise per session? _____
What does a typical exercise session include? E.g. walking, running, swimming, group fitness.
_____
Indicate your current physical activity during an average work day:
___ sitting most of the time, with very little movement
___ walking around, moving some of the time, but mostly sitting
___ fairly active, standing or moving most of the time
___ very active, strenuous work for long periods of time with little rest

PERSONAL HEALTH AND FITNESS GOALS

Please list your personal health and fitness goals in order of priority:
1) _____
2) _____
3) _____
Please describe your current physical activity, or a typical exercise session in detail below.
_____
_____

What types of activities, equipment or specific exercises do you prefer?
_____
What barriers to success do you anticipate?
_____
How much time during the week are you able to dedicate to your exercise program?
_____
Please indicate any other medical conditions or activity restriction that you may have. This should include broken bones, recent or abnormal sprains/strains, surgeries, pain when performing certain activities, etc. It is important that this information be as accurate and detailed as possible.
_____
_____

Circle your motivation level:	low	medium	high
Circle your current confidence level:	low	medium	high
Circle your readiness for change:	low	medium	high

Thank you for completing the HHQ. A personal trainer will contact you within 7-10 business days of receiving your HHQ. We look forward to working with you!

I have read, understood, and completed this questionnaire. Any questions I had were answered to my full satisfaction.

NAME: _____
DATE: _____

SIGNATURE: _____

SIGNATURE OF PARENT or GUARDIAN (if under 18): _____

GEORGE MASON UNIVERSITY
INFORMED CONSENT FORM

GENERAL STATEMENT OF PROGRAM OBJECTIVES AND PROCEDURES:
I understand that this physical fitness program includes exercises to condition the cardio-respiratory system, musculoskeletal system, and improve body composition. Exercises will include aerobic activities and/or resistance training, calisthenics, plyometrics, and/or flexibility exercises.

DESCRIPTION OF POTENTIAL RISKS:
I understand that one's tolerance for physical activity cannot be predicted with complete accuracy. I understand that there are certain risks associated with physical activity including exposure to personal injury. Engaging in described exercises may lead to musculoskeletal strains, pain, and/or injury if adequate warm-up, gradual progression, and safety precautions are not followed. I understand that the fitness facilitator shall not be liable for any damages arising from personal injuries sustained by the participant while and during participation in an exercise program. Participant use of exercise equipment is done so at an individual's own risk. Participant assumes full responsibility for any injuries or damages which may occur because of physical activity.

I hereby fully and forever release and discharge the fitness facilitator, its assigns and agents from all claims, demands, damages, rights of action, present and future therein.

I understand and agree that I am in good physical condition and that I have no disability, impairment or ailment preventing me from engaging in active or passive exercise that will be detrimental to heart, safety, comfort, or physical condition.

I understand a recent physical checkup and physician's permission to engage in aerobic and/or anaerobic conditioning is advised.

DESCRIPTION OF POTENTIAL BENEFITS:
I understand regular physical activity is likely to yield many benefits that may include a decrease in body fat, improvement in blood fats and blood pressure, improvement in physiological function, and a decrease in disease risk.

REFUND AND CANCELLATION POLICY:

There are no refunds for any personal training packages. I understand that when I schedule an appointment with my trainer, I am making a commitment to them and myself. If I show up late, I realize that those are minutes that I will not gain back (i.e.: if I am 15 minutes late for an hour-long session, I will only receive a 45-minute session). Additionally, I understand that if I cancel with less than 24 hours' notice, I may still be charged for that session. All Personal Training Packages 90 days from purchase. Any unused sessions will not be refunded.

I have read the information above and understand it. All questions have been answered to my satisfaction.

Signature of Participant _____ Date _____

Signature of Parent or Guardian (if under 18) _____ Date_____

Revised
12/2016

Medical Clearance Form

Dear Doctor:

Your patient _____ wishes to take part in an exercise program and/or fitness assessment. The exercise program may include progressive resistance training, flexibility exercises, and a cardiovascular program; increasing in duration and intensity over time. The fitness assessment may include a sub-maximal cardiovascular fitness test and measurements of body composition, flexibility, and muscular strength and endurance. After completing a readiness questionnaire and discussing his/her medical condition(s) we agreed to seek your advice in setting limitations to their program. Please identify any recommendations or restrictions for your patient's fitness program below (Physician's Recommendations).

Physician's Recommendations

	I am not aware of any contraindications toward participation in a fitness program.
	If your patient is taking medications that will affect their heart rate response to exercise, please indicate the manner of the effect (raises, lowers heart rate response). Type of Medication: _____ _____ Effect:_____ Please, provide the following information: 1. Blood Pressure (sitting) _____ 2. Resting Heart Rate _____BPM 3. Recommended Maximum Heart Rate _____BPM

I believe the applicant can participate, but with the following limitations:

Strength training: ( ) Yes- can participate with the limitations below ( ) No-cannot participate
Limitations: any positions of the body that you recommend your patient should NOT perform, such as floor exercises (laying down on the floor), or exercises with arms over the head:

_____
_____

Aerobic training: ( ) Can participate with the limitations below ( ) No cannot participate
Limitations: _____
_____

Stretch training: ( ) Can participate with the limitations below ( ) No cannot participate
Limitations: _____
_____

Other training please, specify: ( ) Can participate with the limitations below ( ) No cannot participate
Limitations: _____
_____

Physician's signature		Date
Physician's name (print)	Phone	Fax
Address	City	State & Zip