



Date \_\_\_/\_\_\_/\_\_\_

PERSONAL TRAINING QUESTIONNAIRE

Name: \_\_\_\_\_ Address: \_\_\_\_\_
City, State, Zip: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_
Phone # \_\_\_\_\_ Email: \_\_\_\_\_ CWID: \_\_\_\_\_
Affiliation: [ ] Undergrad [ ] Graduate/Doctorate [ ] Faculty/Staff [ ] Alumni [ ] Other: \_\_\_\_\_
Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

- 1.) Please describe your current and/or previous exercise experience:
2.) How many sessions per week would you like to meet with your trainer? \_\_\_\_\_
3.) Are you currently taking any over-the-counter or prescription medications or drugs? If so, please list:
4.) What are your primary health and fitness goals? (Check all that apply)
[ ] Weight Loss [ ] Endurance [ ] Strength [ ] Muscular Endurance [ ] Other \_\_\_\_\_
5.) What are your secondary health and fitness goals? (Check all that apply)
[ ] Energy Enhancement [ ] Sleep Improvement [ ] Stress Relief [ ] Mood Enhancement
6.) Do you prefer working with a: [ ] Male Trainer [ ] Female Trainer [ ] No Preference
7.) Do you have a specific trainer in mind? [ ] Yes [ ] No If yes, please specify \_\_\_\_\_
8.) If purchasing Buddy Training Sessions, please specify the name of your training partner \_\_\_\_\_

PLEASE NOTE: Personal Trainers are assigned based on relevance and open availability. To ensure your prompt assignment to a personal trainer, please list all possible days and times for training sessions. To ensure you receive the best expertise possible, the processing and assignment of a personal trainer may take up to 7 days. Your personal trainer will contact you within 7 days of submitting this form.

Indicate All Available Days and Time

Table with 7 columns (Time slots: 5:30-8am, 8-11am, 11am-2pm, 2-5pm, 5-8pm, 8pm-12am) and 7 rows (Days: MONDAY, TUESDAY, WEDNESDAY, THURSDAY, FRIDAY, SATURDAY, SUNDAY). Saturday and Sunday have shaded cells in the 5:30-8am and 8pm-12am slots.

**Physical Activity Readiness Questionnaire** (American College of Sports Medicine, 1998): Check the appropriate box on each question. A physician's release will be required if you answer "yes" to any item listed in the box below.

**YES NO**

- |                          |                          |                                                                                                                                            |
|--------------------------|--------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Has your doctor ever said that you have a heart condition <u>and</u> that you should only do physical activity recommended by a doctor? |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Do you feel pain in your chest when you do physical activity?                                                                           |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. In the past month, have you had chest pain when you were not doing physical activity?                                                   |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. Do you lose your balance because of dizziness or do you ever lose consciousness?                                                        |
| <input type="checkbox"/> | <input type="checkbox"/> | 5. Do you have a bone or joint problem that could be made worse by a change in your physical activity?                                     |
| <input type="checkbox"/> | <input type="checkbox"/> | 6. Is your doctor currently prescribing drugs (for example, water pills) for your blood pressure or heart condition?                       |
| <input type="checkbox"/> | <input type="checkbox"/> | 7. Do you know of <u>any other reason</u> why you should not do physical activity?                                                         |

**Additional Information:** Please mark all that apply.

- |                          |                                                                                                                   |
|--------------------------|-------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> | 1. Smoke or quit smoking in the last 3 months                                                                     |
| <input type="checkbox"/> | 2. Taking medication for high blood pressure                                                                      |
| <input type="checkbox"/> | 3. Hernia or other condition that may be aggravated by lifting weights                                            |
| <input type="checkbox"/> | 4. Diabetes                                                                                                       |
| <input type="checkbox"/> | 5. Recent surgery (last 12 months) Explain:                                                                       |
| <input type="checkbox"/> | 6. Pregnancy (now or within the last 3 months)                                                                    |
| <input type="checkbox"/> | 7. Pre-existing injuries or physical restrictions that may limit your ability to exercise. If so, please explain: |

**RELEASE AND INDEMNITY AGREEMENT:**

I hereby release the Board of Regents of Oklahoma State University and all its employees from all claims on account of injury which may be sustained while attending this class, and I agree to indemnify the Board of Regents of Oklahoma State University and its employees for any claim which may hereafter be presented as a result of such injuries.

**Print Name** \_\_\_\_\_

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

## PHYSICIAN'S STATEMENT AND CLEARANCE FORM

At the Department of Wellness, your safety is our primary concern. For this reason, we comply with the health and fitness standards of the American College of Sports Medicine.

On the Physical Activity Readiness Questionnaire (PAR-Q), you identified that you have one or more coronary and/or other medical risk factors which may impair your ability to exercise safely. For this reason, you need to have a physician complete and return this medical clearance form before you can begin exercising at the Seretean Wellness Center or the Colvin Recreation Center.

We recognize that you are eager to start your fitness program, and we sincerely regret any inconvenience that this may cause you. However, please keep in mind that we want your exercise experience to be as safe as possible.

Please ask your physician to complete the bottom portion of this form. He/she may fax the form back to us at the number listed below.

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**I hereby give my physician permission to release any pertinent medical information from any medical records to the staff at the Department of Wellness. All information will be kept confidential.**

Patient's name (type or print) \_\_\_\_\_ DOB \_\_\_\_\_

Patient's signature: \_\_\_\_\_ Date: \_\_\_\_\_

Reason for medical clearance \_\_\_\_\_

Physician's name \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_

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### FOR PHYSICIAN USE ONLY

Please check one of the following statements:

- I concur with my patient's participation with no restrictions
- I concur with my patient's participation in an exercise program with the following restrictions:

\_\_\_\_\_

- I **do not** concur with my patient's participation in an exercise program with the Department of Wellness.

Reason \_\_\_\_\_

Physician's name (type or print) \_\_\_\_\_

Physician's signature \_\_\_\_\_ Date \_\_\_\_\_

#### Please return to:

Jason Vlastaras  
Fitness Coordinator  
Colvin Recreation Center  
Phone: 405-744-7531  
Fax: 405-744-7670



DEPARTMENT OF  
**Wellness**

Striving to be America's **HEALTHIEST** Campus