



Date _____

PROGRAM INFORMATION AND POLICIES

Welcome to the *Baylor Tom Landry Fitness Center* personal training program! We are delighted that you chose us as a part of your commitment to health and fitness. Our skilled professionals are ready to provide you with the necessary information and motivation to help you reach and maintain your personal fitness goals.

The following information will provide you with important program policies. Before getting started, please read and sign this form so that we can be sure that you have been provided with and understand this information.

❖ **PAYMENT**

Payment for sessions must be made *in advance* of meeting with your trainer. Before each session, please check in at the Front Desk and advise the Front Desk that you have a training session with your trainer. The Front Desk will print out a session ticket that must be given to the personal trainer before beginning your training session. (NOTE: The first personal training session is a charged session.)

❖ **EXPIRATION DATE**

All *Baylor Tom Landry Fitness Center* personal training sessions have an expiration date of 6-months from the date of purchase. After the expiration date, any remaining sessions will be invalid.

❖ **CANCELLATIONS**

In order to cancel or reschedule an appointment, you must contact your trainer *at least 24 hours in advance* of the scheduled appointment or you will be charged for that session. Similarly, if a trainer does not contact you at least 24 hours in advance to cancel or reschedule an appointment, you will receive a *complimentary* session. (NOTE: any exception to this policy will be made purely at the discretion of the trainer.)

❖ **TARDINESS**

All clients and trainers are encouraged to be prompt. If a client arrives late, this time will be deducted from the session; contrarily, if a trainer arrives late, the amount of time will be *added* for an extended session. Please be advised that trainers are required to wait 15 minutes for a scheduled client, after which time the session is subject to cancellation and clients will be charged for a full session. (NOTE: any exception to this policy will be made purely at the discretion of the trainer.)

❖ **REFUNDS, CREDITS, AND DISCOUNTS**

Baylor Tom Landry Fitness Center offers a 90-day refund policy. Beyond this time period, refunds will not be allowed. Discounts are not offered for Personal Training Services. Please be sure that our services will match your needs *before* committing through payment

I have read and will comply with the above information.

Name (please print)

Signature

Date



Date _____

PERSONAL HEALTH HISTORY

Name _____

Address _____ City, State _____ Zip _____

Telephone (Day) _____ (Eve) _____

Email Address _____

Emergency Contact _____ Telephone _____

Gender _____ Age _____ D.O.B. _____ Occupation _____

Complimentary General Fitness Assessment Completed _____ Yes _____ No (Date: _____)

CARDIOVASCULAR RISK

Please check any that apply and age of onset:

- | | | | |
|--|-------|-----------|---|
| <input type="checkbox"/> High Blood Pressure | _____ | Age _____ | Do you presently smoke cigarettes? ___ Yes ___ No |
| <input type="checkbox"/> High Cholesterol | _____ | | If so, how many per day? _____ |
| <input type="checkbox"/> Diabetes | _____ | | Have you exercised within the past 6 months? |
| <input type="checkbox"/> Heart Disease | _____ | | _____ Yes _____ No |
| <input type="checkbox"/> Bypass Surgery | _____ | | Height _____ Current Weight _____ |
| <input type="checkbox"/> Stroke | _____ | | What was your weight at 21? _____ |

PERSONAL HISTORY

Date of last physical examination _____ Date of last Stress Test _____

Physician's Name _____ Phone: _____

Date of last blood cholesterol test _____ Total Serum Cholesterol _____ HDL _____

Date of last blood pressure test _____ Blood pressure _____

Date of last Resting EKG _____

Has your doctor ever restricted your physical activity? ___ Yes ___ No If yes, please explain _____

Are you currently taking any medication? ___ Yes ___ No

Specify Type and Purpose _____

Do you ever experience chest pains or tightness? ___ Yes ___ No

Do you ever experience unusual shortness of breath during mild physical activity? ___ Yes ___ No

Do you ever experience dizziness during vigorous physical activity? ___ Yes ___ No

Have you ever passed out during vigorous physical activity? ___ Yes ___ No

If you are female, are you currently pregnant? ___ Yes ___ No

INJURIES

Please check any of the following injuries you have had and specify which bone, muscle, joint, etc., and the year the injury occurred:

- Broken bones _____
- Muscle strain/sprain _____
- Ligament, tendon, or cartilage injury _____
- Joint injury or chronic pain _____
- Back injury or chronic pain _____
- Nerve entrapment (e.g. carpal tunnel syndrome) _____
- Other _____

Are you currently being treated for any of the above injuries? ____ Yes ____ No If so, please specify the type of treatment _____

LIFESTYLE

If you are currently employed, do you consider your job to be ____ sedentary or ____ active?

Are you...

- Generally sedentary
- A weekend or vacation exerciser
- Physically active once or twice a week
- Physically active more often

Do you currently have a regular exercise program? ____ Yes ____ No If yes, please describe _____

TRAINING INTEREST AND GOALS

Please check any activities in which you are interested in participating:

- ____ Weight Training ____ Aerobics ____ Rowing ____ Stairmaster ____ Running
- ____ Stationary Bike ____ Swimming ____ Triathlons ____ Walking ____ Other

How much time do you want to spend working out? _____

Do you have any exercise equipment at home? _____

Do you feel that there are any specific exercises that would not interest you or might cause you pain or discomfort? _____

What goals do you have concerning your training and health? _____

Why are your goals important? _____

What are your expectations of your personal trainer? _____

Signature _____ Date _____

Name _____

NUTRITIONAL EVALUATION

1. Do you currently follow any special diet or eating plan? ____ Yes ____ No If so, explain: _____

2. What is the lowest weight you have maintained in your adult life? _____
What is the highest weight you have reached? _____
What do you think is a realistic and desired weight for you? _____
What is your current height and weight? Height _____ Weight _____
3. Are you currently taking any type of nutritional supplements, vitamins, herbs, performance enhancing aids, and/or weight loss products? ____ Yes ____ No If so, what type? _____
4. Do you skip any meals? ____ Yes ____ No Which meal(s)? _____
5. Do you snack between meals? ____ Yes ____ No
If so, what do you snack on? _____
6. How much water do you consume throughout the day? _____
Soda (regular/diet) _____ Fruit Juice _____ Coffee (caffeinated/decaffeinated) _____
Tea _____ Alcohol _____
7. How often do you eat out?
____ Less than 1 time/week ____ 1-3 times/week ____ More than 3 times/week ____ Almost every meal
8. What type of restaurants do you choose?
____ Fast Food ____ Sit-down/Casual ____ Sit-down/Formal ____ Cafeteria ____ Deli ____ Other
9. How many times per week do you eat fried foods? _____
10. How many pieces of fruits do you eat daily? _____
How many vegetables do you typically eat daily? _____
11. Do you drink milk? ____ Yes ____ No If so, how much? _____
12. What type of cooking oils do you use? _____
13. What type of bread products do you eat? _____
14. Do you add salt to your food? ____ Yes ____ No
15. Is there a history of excess weight in your family? ____ Yes ____ No
16. In your opinion, what dietary changes do you feel are necessary to reach your personal goals? _____

