PERSONAL TRAINING
FAMILY YMCA OF BLACK HAWK COUNTY

Let one of our certified personal trainers provide you with individual coaching to help you set and meet your wellness goals. During specifically designed workouts that fit your needs, you will learn various exercises that build strength and endurance, reduce body fat, and improve overall cardiovascular fitness. Sessions are one hour long, but can be broken down into 30 minute increments, and are available for individuals or two people. To get started, please fill out the personal training registration form attached to this flyer.

<table>
<thead>
<tr>
<th>Number of Sessions</th>
<th>Individual Member</th>
<th>Partner Members</th>
<th>Family Personal Training</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 sessions</td>
<td>$90</td>
<td>$105</td>
<td></td>
</tr>
<tr>
<td>6 sessions</td>
<td>$168</td>
<td>$198</td>
<td>$99</td>
</tr>
<tr>
<td>10 sessions</td>
<td>$260</td>
<td>$280</td>
<td></td>
</tr>
<tr>
<td>20 sessions</td>
<td>$480</td>
<td>$520</td>
<td></td>
</tr>
</tbody>
</table>

For more information contact Sarah Thompson, sthompson@blackhawkmca.org or 319-233-3531
PERSONAL TRAINING REGISTRATION FORM

PLEASE COMPLETE FORM AND RETURN IT TO THE WELCOME CENTER DESK

CLIENT INFORMATION

Name: ___________________________________________ DOB: ___________________________ Gender: M F

Address: ___________________________________________ Street: ___________ City: ___________ State: ___________ Zip: ___________

Phone: (home)_______________________ (work)_______________________ (cell)_______________________

Email address: __________________________________________________________

Name: ___________________________________________ DOB: ___________________________ Gender: M F

Address: ___________________________________________ Street: ___________ City: ___________ State: ___________ Zip: ___________

Phone: (home)_______________________ (work)_______________________ (cell)_______________________

Email address: __________________________________________________________

In case of emergency contact:

Name ___________________________ Phone ___________________________ Relationship ___________________________

Physician’s Name: ___________________________ Physician’s Phone: ___________________________

Date of last physical exam: ___________________________

Names, Ages and Birthdates of Children: __________________________________________________________

CLIENT AVAILABILITY AND TRAINER PREFERENCE

Please indicate specific time you’re available

Mon _______________ Wed _______________ Fri _______________ Sun _______________

Tues _______________ Thur _______________ Sat _______________

Trainer Preference: Male Female Specific Trainer: ___________________________

I have no Personal Trainer Preference: ___________________________
# General Medical History

<table>
<thead>
<tr>
<th>Question</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Has a physician ever said you have a heart condition and that you should only do physical activity recommended by a physician?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>When do physical activity, do you feel pain in your chest?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you had chest pain in the last month when you were not doing physical activity?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you ever lose consciousness or do you lose your balance because of dizziness?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you have a joint or bone problem that may be made worse by a change in your physical activity?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is a physician currently prescribing medications for your blood pressure or heart condition?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are you pregnant?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you have insulin dependent diabetes?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are you 69 years of age or older?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you know of any reason you should not exercise or increase your physical activity?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Note:** If you answered YES to any of the above questions, you will need to get a doctor’s release before participating in this program.

Please check any of the following conditions you currently have or have experienced in the past: (check all that apply)

- Rheumatic fever
- Recent surgery
- Edema (swelling of ankles)
- High blood pressure
- Low blood pressure
- Low back pain
- Seizures
- Heat stroke
- Heart attack, coronary bypass, or other cardiac surgery
- Arthritis
- Migraine or recurring headache
- Anemia
- Hernia
- Bronchitis
- Pain/discomfort in the chest, neck, jaw
- Known heart murmur
- Increased anxiety
- Depression
- Stroke
- Fainting or dizziness
- Diabetes
- Unusual shortness of breath
- Chest pains
- Arthritis
- Asthma
- Bursitis
- Pneumonia
- Lung disease
- Extra, skipped, or rapid heart beats
- Have you injured or do you have current pain in any of the following areas:
  - Neck
  - Shoulder
  - Elbow
  - Wrist
  - Chest/Ribs
  - Upper Back
  - Lower Back
  - Hip
  - Knee
  - Ankle
  - Foot

Please explain any checked items:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

MEDICATIONS

Please list any prescribed medications that you are currently taken:

<table>
<thead>
<tr>
<th>Medication</th>
<th>Reason</th>
<th>Taken for how long</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
WEIGHT HISTORY

Has your weight changed significantly in the past year? YES NO NOT SURE

If yes, did you gain or lose weight? GAIN LOSE AMOUNT_________ lbs.

If yes, was the weight loss intentional or unintentional? INTENTIONAL UNINTENTIONAL

EXPLAIN (if necessary):
_________________________________________________________________________________________________
_________________________________________________________________________________________________
_________________________________________________________________________________________________

NUTRITION

How many times do you usually eat per day? __________

Select the meals and snacks that you consume in an average day:

BREAKFAST  SNACK  LUNCH  SNACK  DINNER  SNACK

Do you regularly skip meals? YES NO

If you answered yes, list which meals you skip most often and why:
_________________________________________________________________________________________________
_________________________________________________________________________________________________

On a scale of 1 – 10, how motivated are you to make changes to your diet at this time?
(1= not motivated, 10 = greatest motivation you have ever had)

Your Rating: ________

LIFESTYLE

Do you smoke? YES NO

Describe your job (1=sedentary, 10=very active): __________

How would you rate your current stress level (1=very low, 10=very high): __________
On a scale of 1 to 10, how would you rate your current fitness level (1=very low, 10=very high): _____________

How long has it been since the last time you performed any type of physical activity that increased your heart rate?

____1 Day     ____1 Week     ____1 Month     ____6 Months     ____1 Year     ____Over 1 Year

Have you ever performed resistance training exercises in the past?     YES     NO

Have you ever started an exercise program and then stopped?     YES     NO

If yes, please list any reasons why you stopped...

________________________________________________________________________________________________

________________________________________________________________________________________________

________________________________________________________________________________________________

On a scale of 1 – 10, how motivated are you to make changes to your physical activity level at this time? (1= not motivated,10 = greatest motivation you have ever had)

Your Rating: ____________

What goals would you like to accomplish through participation in this program?

________________________________________________________________________________________________

________________________________________________________________________________________________

________________________________________________________________________________________________

________________________________________________________________________________________________

INFORMED CONSENT and WAIVER OF LIABILITY:

I have read, understood, and completed this questionnaire and answered in a truthful manner to the best of my knowledge. I am currently capable of participating in the YMCA wellness program. I understand the potential risks of injury and agree to assume responsibility for any medical expense associated with any injury incidental to the program. I do further release, absolve, indemnify and hold harmless, The Family YMCA of Black Hawk County, and/or any of the employees, volunteers, agents, insurers, or any other person associated with any or all of them, from and against any claims, demands, liability, cost of suits, damages, loss and/or judgments arising out of participation. In the event of an emergency where I am unable to make a sound decision and/or my emergency contact can not be reached, I authorize YMCA staff to seek emergency assistance at my expense.

Signature: ____________________________________________ Date: ______________

<table>
<thead>
<tr>
<th>STAFF USE ONLY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Sessions Purchased: 3 6 10 20 Family PT</td>
</tr>
<tr>
<td>Date: ______________</td>
</tr>
<tr>
<td>Staff Initials: ______________</td>
</tr>
</tbody>
</table>