

# JUST BE FIT.

FREQUENT  
INTENSIVE  
TRAINING

Client: \_\_\_\_\_

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

## Information:

- \_\_\_\_ Policies and Procedures regarding Gym facilities
- \_\_\_\_ Schedule Sessions
- \_\_\_\_ Business Cards/ Phone Numbers
- \_\_\_\_ Phone Numbers
- \_\_\_\_ Cancellation Policy
- \_\_\_\_ Fee Collection

## Paperwork:

- \_\_\_\_ Billing Contract
- \_\_\_\_ Health History Questionnaire
- \_\_\_\_ Informed Consent- Just Be Fit
- \_\_\_\_ Medical Release
- \_\_\_\_ Food History Questionnaire
- \_\_\_\_ Training Assessment

## Evaluation:

- \_\_\_\_ RHR/THR Range
- \_\_\_\_ Blood Pressure
- \_\_\_\_ Weight
- \_\_\_\_ Circumference
- \_\_\_\_ % Body Fat
- \_\_\_\_ Suggested re-evaluation date
- \_\_\_\_ Goal Setting\*
- \_\_\_\_ Training Log

## Nutrition:

- \_\_\_\_ Food diary
- \_\_\_\_ Eating Tips
- \_\_\_\_ Schedule Consultation Date- \_\_\_\_\_

## E-mail Preferences:

### General

### Specific:

- \_\_\_\_ Arthritis
- \_\_\_\_ Breast Cancer
- \_\_\_\_ Cardiac Rehab
- \_\_\_\_ Diabetes
- \_\_\_\_ Fibromyalgia
- \_\_\_\_ Osteoporosis
- \_\_\_\_ Parkinson's
- \_\_\_\_ Stroke

### Body:

- \_\_\_\_ Back
- \_\_\_\_ Foot
- \_\_\_\_ Leg
- \_\_\_\_ Neck
- \_\_\_\_ Shoulder

### Sport:

- \_\_\_\_ Basketball
- \_\_\_\_ Bowling
- \_\_\_\_ Cycling
- \_\_\_\_ Football
- \_\_\_\_ Golf
- \_\_\_\_ Racquet
- \_\_\_\_ Running
- \_\_\_\_ Skiing
- \_\_\_\_ Soccer
- \_\_\_\_ Swimming
- \_\_\_\_ Volleyball

Target Heart Rate (THR) Determination

Age Predicted

1. Estimate Maximum Heart Rate (Max HR)

220

- \_\_\_\_ (age)

(Max HR)

2. Multiply the desired intensity range (60-90%)

(Max HR)

x .60 (Intensity)

(Target HR)

(Max HR)

x .90 (Intensity)

(Target HR)

Target Heart Rate Range \_\_\_\_\_bpm

**PERSONAL TRAINING**

**HEALTH HISTORY / LIFESTYLE QUESTIONNAIRE**

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_  
PHONE (HOME): ( ) \_\_\_\_\_ CELL: ( ) \_\_\_\_\_  
PHONE (BUSINESS): ( ) \_\_\_\_\_ FAX: ( ) \_\_\_\_\_  
E-MAIL ADDRESS: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_  
AGE: \_\_\_\_\_ BIRTH DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_ HEIGHT: \_\_\_\_\_ WEIGHT \_\_\_\_\_  
MARRIED \_\_\_\_\_ SINGLE \_\_\_\_\_  
Referred By: \_\_\_\_\_

Do you have children? ( ) YES ( ) NO / If so, how many? \_\_\_\_\_ Ages \_\_\_\_\_

In Case of Emergency, Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Home Phone: ( ) \_\_\_\_\_ Phone (Cell): ( ) \_\_\_\_\_  
Work ( ) \_\_\_\_\_

Do you currently have a physician? ( ) YES ( ) NO

I) Physician's Name: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_  
Address: \_\_\_\_\_

II) Physician's Name: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_  
Address: \_\_\_\_\_

**MEDICAL HISTORY**

**Have you ever had, or do you currently have, any of the following:**

- |   |   |
|---|---|
| ( ) Alcohol Abuse Problems                | ( ) Allergies                               |
| ( ) Anemia                                | ( ) Arthritis (Osteo/Rheumatoid/AS)         |
| ( ) Aneurism                              | ( ) Anginia                                 |
| ( ) Asthma                                | ( ) Back/Spinal Injury                      |
| ( ) Bronchitis                            | ( ) Cancer                                  |
| ( ) Chronic Obstructive Pulmonary Disease | ( ) Cerebral Vascular Accident/Stroke       |
| ( ) Cerebral Palsy                        | ( ) Coronary Vascular Disease               |
| ( ) Coronary Artery Disease/Heart Disease | ( ) Circulatory Problems                    |
| ( ) Diabetes Type I, Type II              | ( ) Embolism                                |
| ( ) Emphysema                             | ( ) Epilepsy                                |
| ( ) Fibromyalgia                          | ( ) Gastrointestinal/Stomach Problems       |
| ( ) Gout                                  | ( ) Head Injury                             |
| ( ) Hearing Loss                          | ( ) Heart Attack                            |
| ( ) Hemorrhoids                           | ( ) Hernia                                  |
| ( ) High Blood Pressure / Hypertension    | ( ) High Cholesterol                        |
| ( ) High Triglycerides                    | ( ) Hyperglycemia                           |
| ( ) Hypoglycemia                          | ( ) Crohn's Disease                         |
| ( ) Kidney Disease                        | ( ) Joint Problems (Knee/Shoulder/Hip/Back) |
| ( ) Lung Disease                          | ( ) Low Blood Pressure                      |
| ( ) Muscular Dystrophy                    | ( ) Multiple Sclerosis                      |
| ( ) Osteoporosis                          | ( ) Nervous/Emotional Tension               |
| ( ) Paralysis                             | ( ) Parkinson's Disease                     |
| ( ) Spina Bifida                          | ( ) Poliomyelitis                           |
| ( ) TMJ                                   | ( ) Spinal Cord Injury                      |
| ( ) Tumors                                | ( ) Thyroid Problems                        |
| ( ) Varicose Veins                        | ( ) Other _____                             |

**MEDICAL HISTORY, continued**

Please comment here on any marked answers from above:

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Have you recently experienced:

- Back/leg Pain \_\_\_\_\_
- Blurred or double vision \_\_\_\_\_
- Bowel/Bladder changes \_\_\_\_\_
- Brain Fog \_\_\_\_\_
- Calf pain with exercise \_\_\_\_\_
- Change in speech pattern \_\_\_\_\_
- Chest pain or pressure \_\_\_\_\_
- Constant pain unrelieved by rest or movement \_\_\_\_\_
- Difficulty keeping balance \_\_\_\_\_
- Difficulty sleeping \_\_\_\_\_
- Difficulty swallowing \_\_\_\_\_
- Dizziness, fainting, or blackouts \_\_\_\_\_
- Falls \_\_\_\_\_
- Fatigue \_\_\_\_\_
- Irregular heart beat \_\_\_\_\_
- Headaches/migraines \_\_\_\_\_
- Muscular pain at rest \_\_\_\_\_
- Muscular pain with exertion \_\_\_\_\_
- Numbness or tingling in arms, hands or legs \_\_\_\_\_
- Recurrent cough \_\_\_\_\_
- Ringing in ears \_\_\_\_\_
- Shortness of breath \_\_\_\_\_
- Swollen ankles or legs \_\_\_\_\_
- Swollen, stiff, or painful joints \_\_\_\_\_
- Tremors \_\_\_\_\_
- Unexplained weight gain \_\_\_\_\_
- Unexplained weight loss \_\_\_\_\_
- Unusual skin coloration \_\_\_\_\_
- Unusual weakness or fatigue \_\_\_\_\_
- A wound that does not heal \_\_\_\_\_
- Other \_\_\_\_\_

**INJURIES**

Have you ever had, or do you have, injuries to any of the following:

- ankle, foot     arm, elbow     back     clavicle     Hip
- face     knee, thigh     shoulder     wrist/hand

Please comment here on any marked answer from above:

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**WOMEN'S HEALTH**

- 1. Are you pregnant? ( ) YES ( ) NO
  - 2. When was your last menstrual cycle? \_\_\_\_\_
  - 3. Are you currently ( ) premenopausal ( ) postmenopausal ( ) menopausal
  - 4. List any symptoms that accompany your menstrual cycle: \_\_\_\_\_
- 

**TREATMENT/SURGERIES**

- 1. Have you undergone a complete medical exam within the last year? ( ) YES ( ) NO

2. Please list all medications you are taking:

| Name | Reason | Amount | Frequency | Side Effects |
|------|--------|--------|-----------|--------------|
|------|--------|--------|-----------|--------------|

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3. Please list any homeopathic, herbal, vitamin, and/or mineral products that you are currently taking for the treatment of any condition or deficiency:

| Name | Reason | Amount | Frequency | Side Effects |
|------|--------|--------|-----------|--------------|
|------|--------|--------|-----------|--------------|

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4. Please describe any surgery and/or hospitalizations:

| Procedure | Reasons | Date |
|-----------|---------|------|
|-----------|---------|------|

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5. Please list all current diagnostic test (location & date):

X-Rays: \_\_\_\_\_

MRI: \_\_\_\_\_

CAT Scan: \_\_\_\_\_

ECG: \_\_\_\_\_

Stress Test: \_\_\_\_\_

6. Identify any assistive devices you are currently using (cane, brace, etc.), whether the device was prescribed by a physician, and the reason for the device:

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7. Please identify any past or ongoing treatments by a physician, physical therapist, chiropractor, massage therapist, acupuncturist, etc:

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8. Has your physician ever advised you against exercise? ( ) YES ( ) NO

If YES, why? \_\_\_\_\_

## LIFESTYLE / EXERCISE

### PHYSICAL ACTIVITY

1. Are you currently involved in a regular exercise program? ( ) Yes ( ) No

If so, specify the frequency of exercise:

( ) Regularly (3-4 times/week) ( ) Semi-regularly (1-2 times/week)

( ) Sporadic (1-2 times/month)

And the type of exercise:

( ) Cardiovascular (walk, jog, swim, bike, etc.) ( ) Strength Training

( ) Martial Arts ( ) Yoga ( ) Pilates ( ) Other \_\_\_\_\_

Describe Program: \_\_\_\_\_

2. If you answered "yes" to #1, how long have you been involved in the exercise program?

3. If you answered "yes" to #1, rate your perception of the exertion of your exercise program. ( ) Light ( ) Fairly light ( ) Somewhat hard ( ) Hard

4. If you answered "yes" to #1, what is the duration of each exercise session?

5. If you answered "no" to #1, have you been involved in a regular exercise program in the past:

\_\_\_\_\_ 6 months \_\_\_\_\_ year \_\_\_\_\_ other

If so, specify frequency, duration, type, and intensity:

6. What other exercise, sport, or recreational activities have you participated in: the past 6 months?

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

\_\_\_\_\_ beyond? \_\_\_\_\_

7. Were you a high school and/or college athlete? ( ) Yes ( ) No

If so, please specify the sport(s):

8. What types of physical activity do you consider enjoyable? \_\_\_\_\_

9. What are your personal barriers to exercise (i.e., your reasons for not exercising)?

( ) Lack of time ( ) Lack of motivation ( ) Frustration with lack of results

( ) Lack of knowledge about exercise techniques

( ) Other \_\_\_\_\_

10. What physical activity have you been successful with in the past (like and participated in regularly)? \_\_\_\_\_

11. Do you feel that your weight affects your daily activities? ( ) Yes ( ) No

If so how?

12. How do you rate your current level of fitness?

( ) Very Fit ( ) Fit/Healthy ( ) Average ( ) Below Fit ( ) Unhealthy

**LIFESTYLE / EXERCISE,continued**

**SUPPORT**

13. Do you feel any family, friends, or co-workers have or would have negative feelings (i.e., disapproval, resentment) toward your efforts at physical activity? ( ) Yes ( ) No ( )  
If so, explain\_\_\_\_\_

14. Is your significant other or a close friend involved in any regular physical activity?  
( ) Yes ( ) No  
If so, who? What?\_\_\_\_\_

**OCCUPATION / LEISURE**

15. Does your present occupation require much activity (i.e., walking, getting up and Down, carrying things)? ( ) Yes ( ) No  
If so, explain\_\_\_\_\_

16. Do you sit more than you are on the move at work? ( ) Yes ( ) No

17. What are your leisure activities?\_\_\_\_\_

**STRESSORS**

18. Do you consider your lifestyle as:  
( ) Highly stressful ( ) Moderately stressful ( ) Low Stress

19. What types of things make you feel stressed?\_\_\_\_\_

20. How do you deal with your stress normally?\_\_\_\_\_

**HABITS / MISCELLANEOUS**

21. Have you ever smoked? ( ) Yes ( ) No ( ) Quit  
If so, for how long? \_\_\_\_\_ Do you smoke now? \_\_\_\_\_  
Number of cigarettes/day: \_\_\_\_\_ Approximate date stopped: \_\_\_\_\_

22. Do you consume alcohol? ( ) Yes ( ) No  
# Drinks/day \_\_\_\_\_ What \_\_\_\_\_

23. Do you consume caffeine? ( ) Yes ( ) No # Sodas/day \_\_\_\_\_ # Coffee-Tea/day \_\_\_\_\_

**SLEEP**

24. How many hours of sleep do you get each night?\_\_\_\_\_

25. Is your sleep ( ) continuous ( ) interrupted \_\_\_\_\_  
If it is interrupted, explain \_\_\_\_\_

26. What time do you: go to bed? \_\_\_\_\_ get up? \_\_\_\_\_

27. Is your sleep schedule consistent throughout the week or does it change frequently?  
\_\_\_\_\_

**HEALTH & FITNESS GOALS / FLEXIBILITY**

1. Please identify your reasons for participating in a lifestyle modification program:

- Physician recommendation                       Rehabilitation of injury

Improve:  Cardiovascular fitness                       Flexibility                       Energy Level  
 Body (muscle/fat) composition                       Strength  
 Performance for a specific sport                       Level of fitness

Reduce:  Cardiovascular risk factors                       Body fat / weight  
 Amount of alcohol / cigarette consumption  
 Risk of injuries  
 Stress

2. What is your desired weight? \_\_\_\_\_

3. Where/when did you weigh yourself last? \_\_\_\_\_

4. What is the most you have ever weighed? \_\_\_\_\_ Date: \_\_\_\_\_

5. What is the least you have ever weighed? \_\_\_\_\_ Date: \_\_\_\_\_

6. Has your weight fluctuated **5** (five) pounds or more over the past **5** (five) years?  
 YES                       NO

7. Do you consider yourself overweight?                       YES                       NO

8. Times of day that you will make available for exercise \_\_\_\_\_

9. Facilities available to you (home, fitness center, work, etc.):

\_\_\_\_\_

10. Describe what you would like to accomplish through your lifestyle modification program? \_\_\_\_\_

\_\_\_\_\_

11. Identify any time restrictions associated with the goals/expectations listed above?

\_\_\_\_\_

(For Office Use Only)

Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**NUTRITION**

1. Are you currently working with a Nutritionist or Dietician? ( ) YES ( ) NO  
If so, name of practitioner\_\_\_\_\_
  
2. Do you have any food allergies or food sensitivities that you know of?  
( ) YES ( ) NO  
If so, what foods are you allergic to or have sensitivities to?\_\_\_\_\_
  
3. Are you, or have you ever been on a diet? ( ) YES ( ) NO  
If yes, explain:\_\_\_\_\_
  
4. Have you ever kept track of your daily caloric intake? ( ) YES ( ) NO  
If so, when?\_\_\_\_\_ How much was it?\_\_\_\_\_
  
5. Number of times (meals/snacks) you eat per day: ( ) 1-2 ( ) 3-4 ( ) 5-6  
( ) 6 or more
  
6. Times of day you eat:\_\_\_\_\_
  
7. Do you usually eat breakfast? ( ) YES ( ) NO # Times/Week: \_\_\_\_\_
  
8. Number of times per WEEK you usually eat the following:  
\_\_\_\_Red Meat \_\_\_\_Chicken/Turkey \_\_\_\_Fish/Seafood \_\_\_\_Fried Foods  
\_\_\_\_Fast Food \_\_\_\_Desserts \_\_\_\_Milk/Cheese \_\_\_\_Bread \_\_\_\_Pasta
  
9. How many times per DAY do you eat: Vegetables?\_\_\_\_\_ Fruit?\_\_\_\_\_
  
10. Do you regularly use any of the following:  
( ) Butter ( ) Sugar ( ) Sweeteners ( ) Salt
  
11. What are your favorite foods?\_\_\_\_\_
  
12. What are your least favorite foods?\_\_\_\_\_
  
13. What kinds of foods do you snack on?\_\_\_\_\_
  
14. What are your favorite beverages?\_\_\_\_\_
  
15. Approximately how much water (ounces) do you consume per day?\_\_\_\_\_

(For Office Use Only)

Comments:\_\_\_\_\_

## CARDIOVASCULAR HISTORY

1. Has your physician ever said you have heart or cardiovascular disease?  
( ) YES ( ) NO
2. Have you ever had Rheumatic Fever? ( ) YES ( ) NO
3. Have you ever had any diagnosed heart problems (murmur, valve defect)?  
( ) YES ( ) NO
4. Have you ever experienced abnormal chest pain? ( ) YES ( ) NO
5. Do you have unusual shortness of breath, history of dizziness, or fainting?  
( ) YES ( ) NO
6. Have you ever been diagnosed as having high blood pressure? ( ) YES ( ) NO  
If yes, what value? \_\_\_\_\_/\_\_\_\_\_
7. Have you recently had your blood lipids / cholesterol screened? ( ) YES ( ) NO  
If yes, what were the values? \_\_\_\_\_
8. Are you medicated for any of the situations listed above? ( ) YES ( ) NO

## FAMILY MEDICAL HISTORY

Have your parents, grandparents, or siblings had any of the following (indicate who):

|  |   |   |
|--|---|---|
| <input type="checkbox"/> Anemia                            | <input type="checkbox"/> Asthma               | <input type="checkbox"/> Arthritis                |
| <input type="checkbox"/> Back/Leg Pain                     | <input type="checkbox"/> Cardio/heart disease | <input type="checkbox"/> Congenital Heart disease |
| <input type="checkbox"/> Cancer                            | <input type="checkbox"/> Diabetes             | <input type="checkbox"/> Epilepsy                 |
| <input type="checkbox"/> Fatigue/lack of energy            | <input type="checkbox"/> Feet/ankle swelling  | <input type="checkbox"/> Heart operations         |
| <input type="checkbox"/> High cholesterol                  | <input type="checkbox"/> High blood pressure  | <input type="checkbox"/> Heart attack 50 or under |
| <input type="checkbox"/> Kidney disease                    | <input type="checkbox"/> Lung disease         | <input type="checkbox"/> Heart attack over age 50 |
| <input type="checkbox"/> Migraines                         | <input type="checkbox"/> Phlebitis            | <input type="checkbox"/> Recurrent cough          |
| <input type="checkbox"/> Stroke                            | <input type="checkbox"/> Trouble sleeping     | <input type="checkbox"/> Thyroid problems         |
| <input type="checkbox"/> Stomach/gastrointestinal problems | <input type="checkbox"/> Other                |   |

Comments:

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I, the undersigned, state that I have answered this questionnaire to the best of my knowledge.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

THANK YOU FOR TAKING YOUR TIME TO PROVIDE THIS NEEDED INFORMATION.

(For Office Use Only)

Is a medical clearance form needed? ( ) YES ( ) NO

Email: ( ) General ( ) Specific \_\_\_\_\_



INFORMED CONSENT/RELEASE FOR PARTICIPATION IN A  
PERSONAL FITNESS TRAINING PROGRAM

I, \_\_\_\_\_, hereby consent to voluntarily engage in a personal fitness program. I acknowledge it has been recommended to me by my trainer that a physician of my choice examine me and obtain his/her approval for my participation in a program within 30 days of the date set forth below. Furthermore, within the 12 month period proceeding the date of this release, I have not been advised by a physician or other health care professional of any medical condition which would prevent me from participating safely in a physical fitness conditioning program.

If I am taking prescribed medications, I have informed my trainer and further agree to so inform my trainer promptly of any changes, which my doctor or I have made with regard to use of any medications, or change in medical status. I will be given the opportunity for periodic assessments and evaluations at regular intervals after the start of my program. I have been informed that during my participation of the training session, I will be asked to complete the physical activities unless symptoms such as fatigue, shortness of breath, chest discomfort or pain occur. At that point, I have been advised that it is my complete right to decrease or stop exercise and that it is my obligation to inform the trainer of my symptoms. I hereby state that I have been advised and agree to inform the trainer of my symptoms should any develop.

I understand that during the performance of the program, physical touching and positioning of my body by the trainer may be necessary to assess my muscular and bodily reactions to specific exercises, as well as ensure that I am using proper technique and body alignment. I expressly consent to the physical contact for that stated reasons above.

Having such knowledge, I hereby release and hold harmless, Aaron D. Unger, Just Be Fit, Inc. and its owners, officers, agents and employees from any and all claims, demands, injuries, damages, actions or causes of actions, of whatever kind, which may arise as a result of my participation in a personal training program. I hereby assume all risks connected therewith and consent to participate in a personal fitness program. I have read this form and understand all of its terms.

\_\_\_\_\_  
Participant Signature

\_\_\_\_\_  
Personal Trainer Signature

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

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date

\* If client is under 18 years of age, signature of parent or legal guardian is required.



PATIENT MEDICAL INFORMATION RELEASE

**SIGNED** \_\_\_\_\_ **DATE** \_\_\_\_\_

Dear \_\_\_\_\_ Date \_\_\_\_\_

Fax # \_\_\_\_\_

Thank you for taking your time to fill out the following brief medical clearance for your patient \_\_\_\_\_.

To design and implement an exercise program for your patient please indicate any recommendations or limitations your patient may have to appropriately begin a safe and effective exercise routine.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please list any medications your patient is taking and the heart rate effect.

\_\_\_\_\_  
\_\_\_\_\_

Please include Blood Pressure \_\_\_\_\_ CHOL \_\_\_\_\_

\_\_\_\_\_ has my approval to begin an exercise program with Just Be Fit with the recommendations and/or limitations stated above.

Signed \_\_\_\_\_ Date \_\_\_\_\_

Thank you for your time!

Aaron Unger, Owner.  
Medical Exercise Specialist BS, ACSM, NASM, ACE

**Please return medical clearance form to:**

**JUST BE FIT, INC.**  
**420 Lake Cook Road, Suite 101.**  
**Deerfield, IL 60015**  
**Office (847) 444-1348 or Fax (847) 444-1349**  
**[www.justbefitinc.com](http://www.justbefitinc.com)**



BILLING AGREEMENT

Sessions will be made by appointment at your convenience and the availability of the trainer. Sessions are based on a 60-minute hour. Sessions will take place at Just Be Fit, Inc. (420 Lake Cook Road Deerfield, IL 60015). As a professional courtesy, cancellations must be made at least 24 hours before the scheduled appointment. Personal training sessions canceled inside of 24 hours of the scheduled appointment will be billed at the normal rate of a single session to the client, or clients.

Payments for services are on a pre-pay basis. Bills are issued directly to the client by a trainer and are due upon receipt.

A refund will be given only with the written consent of Just Be Fit, Inc. under the following circumstances:

- 1. A client relocates to another city or location out side the counties of Cook, Lake or Du Page Illinois.
2. The Client suffers a Medical condition that makes it impossible to work with a trainer. In this case, a physician's written notification is required.

Sessions which remain unused for a period of one (1) year after the date of purchase will not be honored.

I, \_\_\_\_\_, have read, understand and accept these policies as they are related to personal fitness training procedures with my trainer.

Acknowledged and Agreed,

Client \_\_\_\_\_ Date \_\_\_\_\_

Witnessed,

Personal Trainer \_\_\_\_\_ Date \_\_\_\_\_

Personal Training

Table with 3 columns: # OF SESSIONS, PRICE PER SESSION, TOTAL COST. Rows include 1, 5, 10, 20 sessions, All Semi Private, and Groups of 3 or more.

\*\*For every new client referral, the existing client receives a gift card for a complementary one-on-one personal training session\*\*



Sports Rehabilitation  
&  
Personal Training

# Workout Pages for Personal Training

Name \_\_\_\_\_ Personal Trainer \_\_\_\_\_

Date \_\_\_\_\_ Time Started \_\_\_\_\_ AM PM Time Finished \_\_\_\_\_ AM PM

Today's Workout \_\_\_\_\_ Wt \_\_\_\_\_ % \_\_\_\_\_

Warm-Up \_\_\_\_\_

Stretching \_\_\_\_\_

| Exercise                 |         |           |           |           |           |           |
|--------------------------|---------|-----------|-----------|-----------|-----------|-----------|
| Resistance Segment (Set) | Warm-Up | Lbs 1 Rep | Lbs 2 Rep | Lbs 3 Rep | Lbs 4 Rep | Lbs 5 Rep |
| 1                        | _____   | _____     | _____     | _____     | _____     | _____     |
| 2                        | _____   | _____     | _____     | _____     | _____     | _____     |
| 3                        | _____   | _____     | _____     | _____     | _____     | _____     |
| 4                        | _____   | _____     | _____     | _____     | _____     | _____     |
| 5                        | _____   | _____     | _____     | _____     | _____     | _____     |
| 6                        | _____   | _____     | _____     | _____     | _____     | _____     |
| 7                        | _____   | _____     | _____     | _____     | _____     | _____     |
| 8                        | _____   | _____     | _____     | _____     | _____     | _____     |
| 9                        | _____   | _____     | _____     | _____     | _____     | _____     |
| 10                       | _____   | _____     | _____     | _____     | _____     | _____     |
| 11                       | _____   | _____     | _____     | _____     | _____     | _____     |
| 12                       | _____   | _____     | _____     | _____     | _____     | _____     |
| 13                       | _____   | _____     | _____     | _____     | _____     | _____     |
| 14                       | _____   | _____     | _____     | _____     | _____     | _____     |
| 15                       | _____   | _____     | _____     | _____     | _____     | _____     |

| Aerobic Activity | Type | Duration | Intensity | Frequency |
|------------------|------|----------|-----------|-----------|
|                  |      |          |           |           |
|                  |      |          |           |           |

Cool Down \_\_\_\_\_

Stretch \_\_\_\_\_

Comments \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



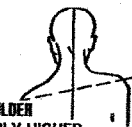
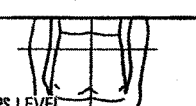
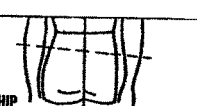
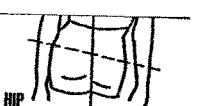



\_\_\_\_\_

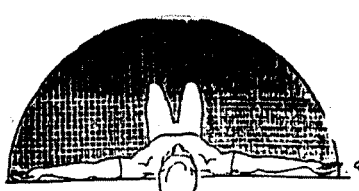



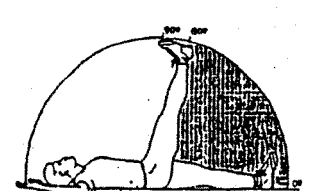


Next Appt \_\_\_\_\_

# JUST BE FIT.

FREQUENT INTENSIVE TRAINING

Clients Name: \_\_\_\_\_

| Training Assessment  |  | Date:   |             | Trainer:        |  |
|--|--|---|-------------|-----------------|--|
| Components<br>Cardiovascular<br>Aerobic  | RHR  | THR   | RPE(1-10)   | BP              |  |
|  | Mode   | Intensity   | Duration    |                 |  |
| <br>SHOULDERS LEVEL<br>(HORIZONTALLY) | <br>ONE SHOULDER<br>SLIGHTLY HIGHER<br>THAN THE OTHER | <br>ONE SHOULDER<br>MARKEDLY HIGHER<br>THAN THE OTHER |             |                 |  |
| <br>HIPS LEVEL<br>(HORIZONTALLY)      | <br>ONE HIP<br>SLIGHTLY HIGHER                        | <br>ONE HIP<br>MARKEDLY HIGHER                        |             |                 |  |
| <br>LOWER BACK<br>NORMALLY CURVED     | <br>LOWER BACK<br>SLIGHTLY HOLLOW                     | <br>LOWER BACK<br>MARKEDLY HOLLOW                      |             |                 |  |
| <b>Posture</b>   |  |   |             |                 |  |
| Head Fwd _____   | Sway back _____  | Shoulders: Higher R / L _____   |             |                 |  |
| Shld rounded _____   | Pelvic tilt _____  | Hips: Higher R / L _____  |             |                 |  |
| Kyphosis _____   | Knees hyperextended _____  | Feet flat _____   |             |                 |  |
| <b>GONIOMETRIC ASSESSMENT</b>  |  |   |             |                 |  |
| <b>MOTION</b>  | <b>NORMAL</b>  | <b>RIGHT</b>  | <b>LEFT</b> | <b>COMMENTS</b> |  |
|  | AVG.   |   |             |                 |  |
|  | AVG.   |   |             |                 |  |
|  | AVG.   |   |             |                 |  |
|  | AVG>   |   |             |                 |  |
|  | AVG.   |   |             |                 |  |
|  | AVG.   |   |             |                 |  |
| <b>Injury / Illness</b>  | Musculoskeletal Risk Factor: ___ no risk, ___ at risk, ___ high risk, ___  |   |             |                 |  |
| <b>Goals and Plan</b>  | Exercise suggestions for Trainer   |   |             |                 |  |

| Flexibility  |
|--|
| <br>Shoulder Abductors          |
| <br>Shoulder Flexors            |
| <br>Shoulder Internal Rotators  |
| <br>Shoulder External Rotators |
| <br>HAMSTRINGS                |
| <br>Hip Flexors               |
| <br>Back Extensors            |

