FOR YOUTH DEVELOPMENT
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

Personal Training

Get started on a personalized, in-depth, barrier breaking YMCA personal training program.
The YMCA offers both personal training and small group training.
All YMCA personal trainers are nationally certified through an accredited association.

What's included?
Goal Setting
Body Composition Analysis
Fitness Assessment
Personalized Exercise Program

Prices
1 hour $35
5 hours $165 (may be broken down into 30 minute sessions)
10 hours $320 (may be broken down into 30 minute sessions)

How will I get contacted?
Return this packet to the welcome center and a personal trainer will contact you directly.

For more information and questions:
Ruth Eltrich
ACE® CERTIFIED PERSONAL TRAINER
563 652-6566
reltrich@scottcountyfamilyy.org

Additional Info:
Please fill out this packet as completely as possible. This will assist us in providing you the best personal training services we can. Depending on your current health status, please be aware that a doctor's approval for an exercise program may be needed.

MAQUOKETA AREA Family Y Personal Training Request Form

FOR YOUTH DEVELOPMENT
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Name_____ Birthdate_____ Gender: M F
Date_____

Phone(s)_____
Email_____

Address_____
EmergencyContact_____

Doctor's
Name_____Phone_____
Are you a Y member? Y N

Height_____ Weight_____Are you currently under a doctor's care? Y N

Please list any medications you are taking and why?
_____
_____
_____
_____

Trainer Preference: M F Either Name of the Trainer you want to work with_____.

What day/s and time/s would you be available to train and how many days/week are you hoping to train? (Please be as specific as possible)

What is your current exercise routine?

What are your primary goals that you hope to accomplish with Personal Training?

MAJOR MEDICAL CONDITIONS (Please check all boxes that apply to you)

- Heart attack
- Heart surgery
- Heart failure
- Heart valve disease
- Coronary angioplasty
- Congenital heart disease
- Joint replacement
- Pacemaker/implantable
- Organ Transplantation (location: _____)
- Cardiac catheterization
- cardiac defibrillator,
- or rhythm disturbance

RISK FACTORS (Please check all boxes that apply to you)

- Please check if you are MALE older than 45 or FEMALE older than 55
- History of high blood pressure OR on antihypertensive medication
- Elevated cholesterol level (total cholesterol higher than 200) or on cholesterol medication
- Current smoker or quit within the last 6 months
- Diabetes
  - Non-insulin dependent over age 35
  - Insulin dependent over age 30
  - Insulin dependent under age 30
  - Insulin dependent for over 15 years
- Family history of coronary artery disease (heart attack or stroke) in parents or siblings
- Sedentary lifestyle (physically inactive)
- Obesity

Please Note:
If you checked 1 or more major medical conditions and/or 2 or more risk factors on this form, exercise approval will be needed from your physician. Please sign here to authorize us to contact your physician. In some cases, a doctor may need to see you in person.

_____
(Signature)

TO BE COMPLETED BY THE PERSONAL TRAINING STAFF CONTACTING THIS INDIVIDUAL.

Date of contact/s _____
Trainer Assigned_____

Maquoketa Area Family YMCA

PAR-Q Medical Health Questionnaire

This form asks you a variety of questions about your medical condition and takes about 5-10 minutes to complete. We do ask some demographic questions in order to help us with ongoing research. Your answer to these questions will be maintained in privacy and will not be associated with your name in any research. Please fill in the information requested, or place a check in the appropriate space. Thank you for your time and effort in completing this questionnaire.

Please print your full name: _____ Today's date: _____

Please circle the highest grade in school you have completed:
High School: 9 10 11 12 College/ Postgrad: 13 14 15 16 17 18 19 20

Marital Status:
Single____ Widowed____ Married____ Divorced/Separated____

Ethnic Background:
Caucasian____ Native American____ Asian_____
Black_____ Pacific Islander____ Hispanic____

Job/Occupation:
(Check the one that applies to the greatest % of your time)
Health Professional____ Manager/Educator____ Service____ Technical/Sales____
Operator/Laborer____ Skilled/Crafts____ Homemaker____ Unemployed____
Retired____ Student____ Disabled ____ Other____

How long have you exercised or played sports regularly?
Not regularly at all____ Less than 1 year____ 1-2 years____
2-5 years____ 5-10 years____ More than 10 years____

Known Diseases
1) Do you have any personal history of heart disease? Y / N
2) Do you have any personal history of metabolic disease? Y / N
3) Have you had diabetes for less than 15 years? Y / N
4) Have you had diabetes for more than 15 years? Y / N
5) Have you experienced unusual pain or discomfort in your chest, neck, jaw, arms, or other areas that may be due to heart problems? Y / N
6) Have you experienced unusual fatigue and/or shortness of breath at rest, during activities, or during mild-moderate exercise? Y / N
7) Have you had any problems with dizziness or fainting? Y / N
8) When you stand up, or sometimes during the night while you are sleeping, do you have difficulty breathing? Y / N

9) Have you experienced an unusual and/or rapid throbbing or fluttering of the heart? Y / N
10) Do you suffer from swelling of the ankles? Y / N
11) Have you experienced severe pain in your leg muscles during walking? Y / N
12) Has a doctor told you that you have a heart murmur? Y / N
13) Has a doctor told you that you have Diabetes or Hypoglycemia? Y / N
14) Are you clinically obese to the point that it interferes with daily tasks? Y / N

HEALTH SCREENING HISTORY

1) During the past year, would you say that you experienced enough stress, strain, and pressure to have a significant effect on your health? Y / N
2) Do you eat foods nearly every day that are high in fat and cholesterol such as fatty meats, cheese, fried foods, butter, whole milk, or eggs? Y / N
3) Do you tend to avoid foods that are high in fiber such as whole grain breads and cereals, fresh fruits, or vegetables? Y / N
4) Do you weigh 30 or more pounds than you should? Y / N
5) Do you average more than two alcoholic drinks each day? Y / N

Please check the item that most closely matches you on each question.

6) When did you have your last medical exam?
_____ Less than 1 year ago _____ 1 year ago _____2 years ago _____3 years ago _____ Never

7) When did you have your last dental exam?
_____ Less than 1 year ago _____ 1 year ago _____2 years ago _____3 years ago _____ Never

8) When did you last have your blood pressure tested by your doctor?
_____ Less than 1 year ago _____ 1 year ago _____2 years ago _____3 years ago _____ Never

9) When did you last have your blood cholesterol tested?
_____ Less than 1 year ago _____ 1 year ago _____2 years ago _____3 years ago _____ Never

10) If you have ever had a treadmill E.C.G. stress test, please indicate how long ago the test was performed. Otherwise, check "Never."
_____ Less than 1 year ago _____ 1 year ago _____2 years ago _____3 years ago _____ Never

11) About how long has it been since you had a rectal exam?
_____ Less than 1 year ago _____ 1 year ago _____2 years ago _____3 years ago _____ Never

12) **For men,** about how long had it been since you had a prostate exam?
_____ Less than 1 year ago _____ 1 year ago _____2 years ago _____3 years ago _____ Never

13) **For women,** how often do you examine your breasts for lumps?
_____Monthly _____Rarely/Never _____Once every few months

14) **For women,** how long has it been since you had your breasts examined by a physician or nurse?
_____ Less than 1 year ago _____ 1 year ago _____2 years ago _____3 years ago _____ Never

15) **For women,** how long has it been since your last breast X-ray?

_____ Less than 1 year ago _____ 1 year ago _____2 years ago _____3 years ago _____ Never

16) **For women,** how long has it been since your last Pap smear test?
_____ Less than 1 year ago _____ 1 year ago _____2 years ago _____3 years ago _____ Never

PERSONAL/FAMILY MEDICAL HISTORY

Please indicate which of the following conditions you have or now have. Also, check medical conditions in your close family. Check as many that apply.

PERSONAL	FAMILY	CONDITION
X	X	Angina
X	X	Peripheral Vascular Disease
X	X	Phlebitis
X	X	Diagnosed Heart problems
X	X	Lung Cancer
X	X	Breast Cancer
X	X	Prostate Cancer
X	X	Skin Cancer
X	X	Other Cancer _____
X	X	Stroke
X	X	COPD
X	X	Pneumonia
X	X	Asthma
X	X	Bronchitis
X	X	Diabetes
X	X	Thyroid problems
X	X	Kidney Disease
X	X	Liver Disease
X	X	Hepatitis
X	X	Gallstones
X	X	Osteoporosis
X	X	Arthritis
X	X	Gout
X	X	Anemia (low iron)
X	X	Bone fracture _____
X	X	Major injury to back or neck
X	X	Stomach/Duodenal Ulcer
X	X	Rectal growth or bleeding
X	X	Cataracts
X	X	Glaucoma
X	X	Hearing loss
X	X	Depression
X	X	High anxiety/phobias
X	X	Substance abuse
X	X	Eating disorders
X	X	Menstruation problem
X	X	Hysterectomy
X	X	Sleeping problems

X	X	Allergies
X	X	Epilepsy
X	X	Any other health problem(s) not started above

_____

_____

MEDICATIONS & SURGERIES

Please check any of the following medications you are currently taking on a regular basis. Also, please give the name of the medication.

Heart Medicine_____

Blood Pressure_____

Blood Cholesterol_____

Hormones_____

Birth Control_____

Asthma/Breathing Problems_____

Insulin/Diabetes Medicine_____

Arthritis_____

Depression_____

Anxiety_____

Thyroid_____

Ulcers_____

Pain Killer_____

Allergy_____

Multi-vitamin/mineral supplement_____

Any Nutritional Herbs, Amino Acids, Muscle Supplements_____

Any Other Medicine W May Need To Know About_____

Please list any operations or surgeries you have had and when you had them

_____ Year _____

_____ Year _____

_____ Year _____

OCCUPATIONAL HEALTH

Please describe your main job duties: _____
_____

	Rarely	**Sometimes**	**Most of the time**	**All of the time**
After work, do you often have pain or stiffness that lasts more than 3 hours?	_____	_____	_____	_____
How often does your work entail repetitive pushing and pulling or lifting while bending/twisting?	_____	_____	_____	_____

	Rarely	**Sometimes**	**Most of the time**	**All of the time**
How often are there high Noise levels on the job so That you have to raise your Voice to be heard?	_____	_____	_____	_____
How often do you handle chemicals on the job which could come in contact with your skin?	_____	_____	_____	_____
How often does the air you breath contain dust or chemical fumes?	_____	_____	_____	_____

EATING HABITS

1) Do you regularly eat high-fiber foods (bran, fruits, vegetables, etc)? Y / N
2) How many glasses of water do you routinely drink each day? _____
3) Are you currently following any type of diet, explain? _____
_____

4) Are you currently taking any type of diet pills or medications (including herbal)?
_____
5) Do you routinely eat breakfast? Y / N
6) How often would you say you skip a meal? Never / Rarely / Frequently / Routinely
7) How many MEALS do you eat on a typical day? 1 / 2 / 3 / 4 / 5 or more
8) Please list the approximate times of your meals _____
_____
9) What would you best describe the size of your meals? _____Smaller than average
_____Average
_____ Larger than average
10) Are you routinely hungry between meals and having snacks? Y / N
11) Do you use protein/nutritional bars or shakes in place of a meal? Y / N

Maquoketa Area Family Y
Personal Training Lifestyle Questionnaire

Name_____
Date_____

Level of Physical Activity

Yes No Do you currently have a regular exercise program such as walking, swimming, cycling or jogging?

Yes No Do you practice weight lifting or other resistance training?

Yes No Do you perform stretching exercises on a regular basis?

Attitudes Toward Exercise

Complete this sentence: "If I do three cardiovascular exercise sessions and two to three resistance training sessions per week, it will…"

Improve my appearance.	Yes	No
Allow me to cope with stress better.	Yes	No
Help me avoid getting sick.	Yes	No
Help me with my daily functional activities.	Yes	No
Increase my self-esteem.	Yes	No
Improve my physical strength.	Yes	No
Improve my ability to concentrate.	Yes	No
Cause pain, soreness, and discomfort.	Yes	No

It Makes me very tired. Yes No

Cause me to get injured. Yes No

Food & Diets

yes no Do you eat breakfast?

yes no Typically, do you eat after 8 p.m.? If so, what do you usually eat?_____

yes no Can you recall ever eating to avoid doing something? If so, when was this?_____

yes no Do you ever eat when you aren't hungry? If so, when?_____

yes no Do you ever "treat" yourself with food? If so, when?_____

yes no Has someone ever encouraged you to eat something that is not in your best interest? If yes, did you do it? Why?

_____

How many times a day do you eat?_____

How much water do you drink daily?_____

Have you ever been on a diet? _____

If so, please answer the following questions:

How many diets have you been on in the last two years? _____

Describe any diets you've been on: _____

_____

Did you go to a commercial weight loss service (Jenny Craig, Diet Center, etc.)?

_____

_____

Did you follow a diet from a book or article? _____

If so, which ones?

_____

_____

When/if you have been on diets, did you lose weight? _____

Did you gain any of it back? _____

How often do you read food labels?

_____

What sources of information about nutrition have you found most helpful?

_____

Do you exercise regularly?

_____

How much time do you have to devote to exercise?

_____

Anything else related to your lifestyle that you think I should know?

_____

_____

Maquoketa Area Family YMCA
INFORMED CONSENT FOR FITNESS TESTING

Name_____
_____ Date: _____

1. PURPOSE AND EXPLANATION OF TEST
The purpose of fitness testing is to evaluate cardio-respiratory fitness, body composition, flexibility, and muscular fitness. The cardio-respiratory or field fitness test involves a sub-maximal test that may include treadmill testing, step testing, 12 minute and 1.5 mile run test and the 1- and 6-minute walk test. Body Composition is analyzed by taking several skin-fold measures to calculate percentage of body fat or using a handheld electronic analyzer. Flexibility is determined by the sit-and-reach test. Muscular strength testing will be performed using various power lifts (i.e., bench press, leg press, squats) and will be measured by1-repetition and/or 4- or 8-rep max testing. Muscular endurance testing will be performed primarily using calisthenics or body weight movements (i.e., push-ups and sit-ups).

2. RISKS
I understand that I am responsible for monitoring my own condition throughout the test, and should any unusual symptoms occur, I will cease my participation and inform the instructor of the symptoms.

In signing this consent form, I affirm that I have read this form in its entirety and that I understand the description of the tests and their components. I also confirm that my questions regarding the fitness testing program have been answered to my satisfaction.

In the event that a medical clearance must be obtained prior to my participation in the fitness testing program, I agree to consult my physician and obtain written permission from my physician prior to the commencement of any fitness tests.

Also, in consideration for being allowed to participate in the fitness testing program, I agree to assume the risk of such testing and further agree to hold harmless the YMCA and its staff members conducting such testing from any and all claims that may result from my injury or death, accidental or otherwise, during or arising in any way from, the testing program.

_____
_____
(Signature of Participant) (Date)

_____
_____
(Person administering tests) (Date)

Personal Training Waiver Form

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This form is an important legal document. It explains the risks you are assuming by beginning an exercise program. It is critical that you read and understand it completely. After you have done so, please print your name legibly and sign in the spaces provided.

Waiver and Covenant Not to Sue

I, _____, have volunteered to participate in a program of physical exercise under the direction of YMCA personal training, which will include, but may not be limited to cardiovascular and weight and/or resistance training. In consideration of YMCA Personal Training agreement to instruct, assist, and train me, I do here and forever release and discharge and hereby hold harmless YMCA Personal Training and their respective agents, heirs, assigns, contractors, and employees from any and all claims, demands, damages, rights of action or causes of action, present or future, arising out of or connected with my participation in this or any exercise program including any injuries resulting from them.

Assumption of Risk

I, _____, recognize that exercise might be difficult and strenuous and that there could be dangers inherent in exercise for some individuals. I acknowledge that the possibility of certain unusual physical changes during exercise does exist. These changes include abnormal blood pressure, fainting, disorders in heartbeat, heart attack, and in rare instances, death.

I understand that I am responsible for monitoring my own condition throughout each session, and should any unusual symptoms occur, I should cease my participation and inform the trainer of these symptoms.
I understand that as a result of my participation in an exercise program, I could suffer an injury or physical disorder that could result in my becoming partially or totally disabled and incapable of performing any gainful employment or having a normal social life.

I recognize that the **YMCA Staff, Physical Education Committee and Board of Directors recommend to every person joining a physical fitness program through the YMCA that he/she undergo a complete physical examination by his/her personal physician prior to involvement in any exercise program.**

If I, _____, have chosen not to obtain a physician's permission prior to beginning this exercise program with YMCA Personal Training, I hereby agree that I am doing so at my own risk.
In any event, I acknowledge and agree that I assume the risks associated with any and all activities and/or exercises in which I participate.

I acknowledge and agree that no warranties or representations have been made to me regarding the results I will achieve from this program. I understand that results are individual and may vary.

_____
Participant's signature

_____ _____
Please print name **Date**

_____
Staff Witness

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