DEPARTMENT OF
Wellness
Striving to be America's HEALTHIEST Campus

Date_____/_____/_____

PERSONAL TRAINING QUESTIONNAIRE

First Name: ___________________________________Last Name: ____________________________________

Address 1:____

Address 2: ____

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.) Do you plan to exercise in addition to personal training sessions? If so, how many times per week? ____

4.) Are you currently taking any over-the-counter or prescription medications or drugs? If so, please list:

5.) What are your health and fitness goals? (Check all that apply)

☐ Weight Loss ☐ Cardiovascular Exercise ☐ Muscle Strength and Endurance ☐ Flexibility

☐Other ___________________

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. ________________________

Check Preferred Times/Days	Early Morning 6-8am	Mid-Morning 9-11am	Early Afternoon 12-2pm	Mid-Afternoon 3-5pm	Early Evening 6-8pm	Late Evening 9-12am
MONDAY						
TUESDAY						
WEDNESDAY						
THURSDAY						
FRIDAY						
SATURDAY						
SUNDAY						

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

Additional Information: Please mark all that apply.

☐ 1. Smoke or quit smoking in the last 3 months
☐ 2. Taking medication for high blood pressure
☐ 3. Hernia or other condition that may be aggravated by lifting weights
☐ 4. Diabetes
☐ 5. Recent surgery (last 12 months) Explain:

☐ 6. Pregnancy (now or within the last 3 months)
☐ 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.

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 _____________

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:

Preston Nesemeier, B.S.
Fitness Coordinator
Seretean Wellness Center
Phone: 405-744-2379
Fax: 405-744-7670

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