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. _____________________

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<th>Check Preferred Times/Days</th>
<th>Early Morning 6-8am</th>
<th>Mid-Morning 9-11am</th>
<th>Early Afternoon 12-2pm</th>
<th>Mid-Afternoon 3-5pm</th>
<th>Early Evening 6-8pm</th>
<th>Late Evening 9-12am</th>
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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

☐ 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