



Date \_\_\_\_\_

## ***PROGRAM INFORMATION AND POLICIES***

Welcome to the *Baylor Tom Landry Fitness Center* personal training program! We are delighted that you chose us as a part of your commitment to health and fitness. Our skilled professionals are ready to provide you with the necessary information and motivation to help you reach and maintain your personal fitness goals.

The following information will provide you with important program policies. Before getting started, please read and sign this form so that we can be sure that you have been provided with and understand this information.

❖ **PAYMENT**

Payment for sessions must be made *in advance* of meeting with your trainer. Before each session, please check in at the Front Desk and advise the Front Desk that you have a training session with your trainer. The Front Desk will print out a session ticket that must be given to the personal trainer before beginning your training session. (NOTE: The first personal training session is a charged session.)

❖ **EXPIRATION DATE**

All *Baylor Tom Landry Fitness Center* personal training sessions have an expiration date of 6-months from the date of purchase. After the expiration date, any remaining sessions will be invalid.

❖ **CANCELLATIONS**

In order to cancel or reschedule an appointment, you must contact your trainer *at least 24 hours in advance* of the scheduled appointment or you will be charged for that session. Similarly, if a trainer does not contact you at least 24 hours in advance to cancel or reschedule an appointment, you will receive a *complimentary* session. (NOTE: any exception to this policy will be made purely at the discretion of the trainer.)

❖ **TARDINESS**

All clients and trainers are encouraged to be prompt. If a client arrives late, this time will be deducted from the session; contrarily, if a trainer arrives late, the amount of time will be *added* for an extended session. Please be advised that trainers are required to wait 15 minutes for a scheduled client, after which time the session is subject to cancellation and clients will be charged for a full session. (NOTE: any exception to this policy will be made purely at the discretion of the trainer.)

❖ **REFUNDS, CREDITS, AND DISCOUNTS**

*Baylor Tom Landry Fitness Center* offers a 90-day refund policy. Beyond this time period, refunds will not be allowed. Discounts are not offered for Personal Training Services. Please be sure that our services will match your needs *before* committing through payment

*I have read and will comply with the above information.*

\_\_\_\_\_  
Name (please print)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date



Date \_\_\_\_\_

**PERSONAL HEALTH HISTORY**

Name \_\_\_\_\_

Address \_\_\_\_\_ City, State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone (Day) \_\_\_\_\_ (Eve) \_\_\_\_\_

Email Address \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Telephone \_\_\_\_\_

Gender \_\_\_\_\_ Age \_\_\_\_\_ D.O.B. \_\_\_\_\_ Occupation \_\_\_\_\_

Complimentary General Fitness Assessment Completed \_\_\_\_\_ Yes \_\_\_\_\_ No (Date: \_\_\_\_\_)

**CARDIOVASCULAR RISK**

Please check any that apply and age of onset:

- |                                              |       |           |                                                   |
|----------------------------------------------|-------|-----------|---------------------------------------------------|
| <input type="checkbox"/> High Blood Pressure | _____ | Age _____ | Do you presently smoke cigarettes? ___ Yes ___ No |
| <input type="checkbox"/> High Cholesterol    | _____ |           | If so, how many per day? _____                    |
| <input type="checkbox"/> Diabetes            | _____ |           | Have you exercised within the past 6 months?      |
| <input type="checkbox"/> Heart Disease       | _____ |           | _____ Yes _____ No                                |
| <input type="checkbox"/> Bypass Surgery      | _____ |           | Height _____ Current Weight _____                 |
| <input type="checkbox"/> Stroke              | _____ |           | What was your weight at 21? _____                 |

**PERSONAL HISTORY**

Date of last physical examination \_\_\_\_\_ Date of last Stress Test \_\_\_\_\_

Physician's Name \_\_\_\_\_ Phone: \_\_\_\_\_

Date of last blood cholesterol test \_\_\_\_\_ Total Serum Cholesterol \_\_\_\_\_ HDL \_\_\_\_\_

Date of last blood pressure test \_\_\_\_\_ Blood pressure \_\_\_\_\_

Date of last Resting EKG \_\_\_\_\_

Has your doctor ever restricted your physical activity? \_\_\_ Yes \_\_\_ No If yes, please explain \_\_\_\_\_

Are you currently taking any medication? \_\_\_ Yes \_\_\_ No

Specify Type and Purpose \_\_\_\_\_

Do you ever experience chest pains or tightness? \_\_\_ Yes \_\_\_ No

Do you ever experience unusual shortness of breath during mild physical activity? \_\_\_ Yes \_\_\_ No

Do you ever experience dizziness during vigorous physical activity? \_\_\_ Yes \_\_\_ No

Have you ever passed out during vigorous physical activity? \_\_\_ Yes \_\_\_ No

If you are female, are you currently pregnant? \_\_\_ Yes \_\_\_ No

**INJURIES**

Please check any of the following injuries you have had and specify which bone, muscle, joint, etc., and the year the injury occurred:

- Broken bones \_\_\_\_\_
- Muscle strain/sprain \_\_\_\_\_
- Ligament, tendon, or cartilage injury \_\_\_\_\_
- Joint injury or chronic pain \_\_\_\_\_
- Back injury or chronic pain \_\_\_\_\_
- Nerve entrapment (e.g. carpal tunnel syndrome) \_\_\_\_\_
- Other \_\_\_\_\_

Are you currently being treated for any of the above injuries? \_\_\_\_ Yes \_\_\_\_ No If so, please specify the type of treatment \_\_\_\_\_

**LIFESTYLE**

If you are currently employed, do you consider your job to be \_\_\_\_ sedentary or \_\_\_\_ active?

Are you...

- Generally sedentary
- A weekend or vacation exerciser
- Physically active once or twice a week
- Physically active more often

Do you currently have a regular exercise program? \_\_\_\_ Yes \_\_\_\_ No If yes, please describe \_\_\_\_\_

**TRAINING INTEREST AND GOALS**

Please check any activities in which you are interested in participating:

- \_\_\_\_ Weight Training      \_\_\_\_ Aerobics      \_\_\_\_ Rowing      \_\_\_\_ Stairmaster      \_\_\_\_ Running
- \_\_\_\_ Stationary Bike      \_\_\_\_ Swimming      \_\_\_\_ Triathlons      \_\_\_\_ Walking      \_\_\_\_ Other

How much time do you want to spend working out? \_\_\_\_\_

Do you have any exercise equipment at home? \_\_\_\_\_

Do you feel that there are any specific exercises that would not interest you or might cause you pain or discomfort? \_\_\_\_\_

What goals do you have concerning your training and health? \_\_\_\_\_

Why are your goals important? \_\_\_\_\_

What are your expectations of your personal trainer? \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Name \_\_\_\_\_

***NUTRITIONAL EVALUATION***

1. Do you currently follow any special diet or eating plan? \_\_\_\_ Yes \_\_\_\_ No If so, explain: \_\_\_\_\_  
\_\_\_\_\_
2. What is the lowest weight you have maintained in your adult life? \_\_\_\_\_  
What is the highest weight you have reached? \_\_\_\_\_  
What do you think is a realistic and desired weight for you? \_\_\_\_\_  
What is your current height and weight? Height \_\_\_\_\_ Weight \_\_\_\_\_
3. Are you currently taking any type of nutritional supplements, vitamins, herbs, performance enhancing aids, and/or weight loss products? \_\_\_\_ Yes \_\_\_\_ No If so, what type? \_\_\_\_\_
4. Do you skip any meals? \_\_\_\_ Yes \_\_\_\_ No Which meal(s)? \_\_\_\_\_
5. Do you snack between meals? \_\_\_\_ Yes \_\_\_\_ No  
If so, what do you snack on? \_\_\_\_\_
6. How much water do you consume throughout the day? \_\_\_\_\_  
Soda (regular/diet) \_\_\_\_\_ Fruit Juice \_\_\_\_\_ Coffee (caffeinated/decaffeinated) \_\_\_\_\_  
Tea \_\_\_\_\_ Alcohol \_\_\_\_\_
7. How often do you eat out?  
\_\_\_\_ Less than 1 time/week \_\_\_\_ 1-3 times/week \_\_\_\_ More than 3 times/week \_\_\_\_ Almost every meal
8. What type of restaurants do you choose?  
\_\_\_\_ Fast Food \_\_\_\_ Sit-down/Casual \_\_\_\_ Sit-down/Formal \_\_\_\_ Cafeteria \_\_\_\_ Deli \_\_\_\_ Other
9. How many times per week do you eat fried foods? \_\_\_\_\_
10. How many pieces of fruits do you eat daily? \_\_\_\_\_  
How many vegetables do you typically eat daily? \_\_\_\_\_
11. Do you drink milk? \_\_\_\_ Yes \_\_\_\_ No If so, how much? \_\_\_\_\_
12. What type of cooking oils do you use? \_\_\_\_\_
13. What type of bread products do you eat? \_\_\_\_\_
14. Do you add salt to your food? \_\_\_\_ Yes \_\_\_\_ No
15. Is there a history of excess weight in your family? \_\_\_\_ Yes \_\_\_\_ No
16. In your opinion, what dietary changes do you feel are necessary to reach your personal goals? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_