Personal Training Pre-Screening

Date:________________

Name:______________________________Age_____________Phone#________________________

Duration of Session (circle one): 1 hour or ½ hour

☐ Talk about pricing structure and cancelation policy. Team Member Initials_________

Preferred Location (circle one): Wellness Center or Off-site

Preferred day(s): Monday Tuesday Wednesday Thursday Friday Saturday Sunday

Preferred Time (circle one): 5a – 8a 8a – 11a 11a – 1p 1p – 4p 4p – 6p 6p - ++

How many sessions per week? 1 2 3 4 5 6

Screening Questions:

1. List any recent injuries surgeries?

   ☐ Spinal ☐ Knee ☐ Hip
   ☐ Shoulder ☐ Foot ☐ Other:_______________________________

2. What activities do you participate in outside of the gym?

   ☐ Walking ☐ Running ☐ Other:_______________________________

3. Do you have any health concerns or considerations?___________________________________

4. What are your short-term goals?

   ☐ Weight Loss ☐ Strength ☐ Flexibility ☐ General Fitness

5. Rate your daily activity. 1 is sedentary and 10 is on your feet all day and moving.

   1 2 3 4 5 6 7 8 9 10

Office Use: 24 Hour Cancel Policy ____ Personal Trainer:_______________________________

_____Front Desk submits in PT WhatsApp: _____________________________

_____Front Desk scans in Profile & files in Front Desk PT Binder.

Medical Release to be sent to Physician: YES NO Medical Release Signed and Completed YES NO

Comments:____

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Appointment Cancellation Policy

1. The Wellness Center requires a 24 (twenty-four) hour notice to cancel or reschedule any scheduled appointment.

2. A $25.00 (twenty-five) rescheduling fee is required if an appointment is rescheduled within 24 hours. If an appointment is missed or cancelled within 24 hours, the Client will be charged the full rate of service. Any services booked without a pre-authorized payment method on file with the Wellness Center must be paid in full prior to scheduling.

3. If there is a change to the Client's contact information, it is the responsibility of the client to ensure the Wellness Center has an up to date email and/or mobile phone number to receive communication from and about the facility and scheduled services.

4. The Wellness Center reserves the right to charge a $25.00 fee for insufficient funds.

____ ____

First Name Last Name

______________________________________ ____

Email Address

______________________________ ______/_______ _________ ______________

Credit Card number Expiration Date CVV Billing Zip Code

X____ ______________

Signature Date

** by signature above, I state that I understand the cancellation policy set herein.

Employee: ______________________________ Date: _____________

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Medical Release

Please complete the following information

It is my understanding that ___________________________________ will be participating in a fitness evaluation and exercise program. This patient is permitted to participate in the following activities. *(Please check all that apply.)*

1. Comprehensive physical fitness assessment including:
   - D submaximal aerobic capacity test for cardiovascular endurance
   - D resting heart rate, resting blood pressure
   - D body composition analysis
   - D flexibility
   - D baseline upper and lower body strength measures
   - D baseline upper and lower body endurance measures
   - D other: ______________________________

2. Exercise/rehabilitation program including:
   - D resistance exercise program
   - D cardiovascular exercise program
   - D nutritional recommendations from registered dietitian
   - D other: ______________________________

Please check the appropriate response:

- D This patient may participate with no restrictions.
- D This patient may participate with the following limitations:

- D This patient may not participate. *(If checked, the individual will not be accepted.)*
- D Other:

Diagnosis/Recommendations/Comments:

Signature

PHYSICIAN NAME *(please print)*

PHYSICIAN SIGNATURE DATE

PARTICIPANT NAME *(please print)*

PARTICIPANT SIGNATURE DATE