Partner(s) Personal Training
For New Clients

5 reasons for personal training with a friend:

1. **Social support and accountability**
2. **Incorporation of partner exercises**
3. **Competition/support provides better fitness results**
4. **Cost effective**
5. **It's fun**

Client's Name (Leader): _____ Phone: _____
R#:_____Email:_____
Age: ____ Sex: ☐ M ☐ F

Client's Name (2): _____ Phone: _____
R#:_____Email:_____
Age: ____ Sex: ☐ M ☐ F

(Optional)
Client's Name (3): _____ Phone: _____
R#:_____Email:_____
Age: ____ Sex: ☐ M ☐ F

Trainer Preferred: ☐ M☐ F Name: _____

Check all that apply:

Package Rate Per Person:

- ☐ 3 Session $63
- ☐ 5 Sessions $105
- ☐ 8 Sessions $152
- ☐ 12 Sessions $228
- ☐ 16 Sessions $288

Fitness Assessment (Per Person)

- ☐ Comprehensive Fitness Assessment $50
- ☐ Comprehensive Fitness Assessment $45 (With the purchase of a Personal Training Package)

TO BE COMPLETED BY FRONT DESK STAFF

Health History Intake Form Complete: ☐ Client 1 ☐ Client 2 ☐ Client 3(optional)
Exercise History/Attitude Questionnaire Complete: ☐ Client 1 ☐ Client 2 ☐ Client 3(optional)

Date received: _____ Payment $_____Receipt#_____Staff Initials: _____
Date received: _____ Payment $_____Receipt#_____Staff Initials: _____
Date received: _____ Payment $_____Receipt#_____Staff Initials: _____

TO BE COMPLETED BY SUPERVISOR

Assigned To: _____ Date Assigned: _____ Session Expire: _____

Client's stratification:
☐ Low Risk
☐ Moderate Risk
☐ High Risk

TO BE COMPLETED BY PERSONAL TRAINER

Date Started: _____Date Completed: _____
Notes:

Trainer's Signature: _____

Partner(s) Personal Training Rules:

- The Group Leader will be the main contact for the trainer/supervisor. It is the group leader's responsibility to relay information to his or her partner(s).

- Each member must sign and complete the Health History and PAR-Q forms

- Each member must pay before meeting with a trainer

- You and your partner(s) MUST have similar training goals

- Sessions will NOT be broken into individual make-up training times if a group member cannot make a session

- Each person in the group will do the same workout – modifications will be provided as needed

TEXAS TECH UNIVERSITY

Group Leader:_____ Phone Number_____ Best time to call_____

**** SCHEDULING WHEN YOUR GROUP CAN WORKOUT WITH YOUR TRAINER****

Days/Times Available to train (Please fill out ALL 5 options):

Option 1:_____

Option 2:_____

Option 3:_____

Option 4:_____

Option 5:_____

- **How many days per week do you want to work out with your trainer?**

  1☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

- **What are your goals that you're trying to achieve through group training?**
  (Please be as specific as possible)

_____
_____
_____
_____
_____
_____
_____

Please keep in mind that the busiest time to work out is between the hours of 4-7pm M-Th, making space to train challenging. If those are the only times the group can work out, then the trainer will do his/her best to make it work.

Personal Training
Health History & PAR-Q
Intake Form

Name: _____Date: _____

Phone:_____Email:_____

Age: _____ Sex: ☐ Male ☐ Female Height:_____ft_____inches Weight:_____lbs

Physician's Name _____Physician's Phone (__)_____

Person to Contact in Case of an Emergency:
Name _____ Date _____ Phone _____

Pre-participation Screening Questionnaire

Assess your health status by marking all true statements

History

You have had:

- ☐ A heart attack
- ☐ Heart surgery
- ☐ Cardiac catheterization
- ☐ Coronary angioplasty (PTCA)
- ☐ Pacemaker/implantable cardiac defibrillator
- ☐ Heart valve disease
- ☐ Heart failure
- ☐ Heart transplantation
- ☐ Congenital heart disease

If you marked any of these statements in this section, consult your physician or other appropriate health care provider before engaging in exercise. You will have to obtain written medical clearance from your physician and may need to use a facility with a **medically qualified staff.**

Symptoms

- ☐ You experience chest discomfort with exertion.
- ☐ You experience unreasonable breathlessness.
- ☐ You experience dizziness, fainting, or blackouts.
- ☐ You take heart medications.

Other Health Issues:

- ☐ You have diabetes.

- ☐ You have asthma or other lung disease.
- ☐ You have burning or cramping sensation in your lower legs when walking short distances.
- ☐ You have musculoskeletal problems that limit your physical activity.
- ☐ You have concerns about the safety of exercise.
- ☐ You take prescriptions medication(s).
  - ○ Please list all medications:_____
- ☐ You are pregnant.

Cardiovascular risk factors

- ☐ You are a man older than 45 years.
- ☐ You are a woman older than 55 years, have had a hysterectomy, or are postmenopausal.
- ☐ You smoke, or quit smoking within the previous 6 months.
- ☐ Your blood pressure is > 140/90 mm Hg.
- ☐ You do not know your blood pressure.
- ☐ You take blood pressure medication.
- ☐ Your blood cholesterol level is >200 mg/dL.
- ☐ You do not know your cholesterol level.
- ☐ You have a close blood relative who had a heart attack or heart surgery before age 55 (father or brother) or age 65 (mother or sister).
- ☐ You are physically inactive (i.e., you get <30 minutes of physical activity on at least 3 days/week).
- ☐ You are >20 pound overweight.

If you marked two or more statements in this section, consult your physician or other appropriate health care provider before engaging in exercise. You may have to obtain written medical clearance from your physician and you might benefit from using a facility with a **professionally qualified exercise** staff to guide your exercise program.

- ☐ None of the above

You should be able to exercise safely without consulting your physician or other appropriate health care provider in a self-guided program or almost any facility that meets your exercise program needs.

Please note: If your health changes so that you then answer YES to any of the above questions, tell your fitness or health professional. Ask whether you should change you physical activity plan. Texas Tech's Department of Recreational Sports and their agents assume no liability for persons who undertake physical activity, and if in doubt after completing this questionnaire, please consult your doctor prior to physical activity.

"I have read, understood, and completed this questionnaire. Any questions I had were answered to my full satisfaction."

Name_____

Signature_____

Signature of Parent_____

(for participants under the age the majority)

Date _____

Note: This physical activity clearance is valid for a maximum of 12 months from the date it is completed and becomes invalid if your condition changes so that you would answer YES to any of the questions.

Exercise History and Attitude Questionnaire

Name: _____ Date: _____

General Instructions: Please fill out this form as completely as possible. If you have any questions, please ask your trainer for assistance.

1. Rate yourself on a scale of 1 to 5 (1 indicating the lowest value and 5 indicating the highest). Circle the number that BEST applies.

   a) Characterize your present athletic ability.
   1 2 3 4 5

   b) When you exercise, how important is competition?
   1 2 3 4 5

   c) Characterize your present cardiovascular capacity.
   1 2 3 4 5

   d) Characterize your present muscular capacity.
   1 2 3 4 5

   e) Characterize your present flexibility capacity.
   1 2 3 4 5

2. Were you a high school and/or college athlete? ☐ YES ☐ NO
   a. If yes, please specify: _____

3. Do you have any negative feelings toward, or have you had any bad experience with, fitness testing and evaluation? ☐ YES ☐ NO
   a. If yes, please explain: _____

4. Do you start exercise programs but then find yourself unable to stick with them?
   ☐ YES ☐ NO

5. How much are you willing to devote to an exercise program? _____minutes/day _____ days/week

6. What types of exercises interest you?

a.	☐ Walking	☐ Jogging	☐ Yoga and Pilates
b.	☐ Cycling	☐ Dance exercise	☐ Strength training
c.	☐ Stationary biking	☐ Rowing	☐ Swimming
d.	☐ Tennis/Racquetball	☐ Group exercise	☐ Stretching

7. Are you currently involved in regular endurance (cardiovascular) exercise?
   a. ☐ YES ☐ NO

If yes, what type of exercise(s) _____ _____ minutes/day
_____days/week

8. Rate your perception of the exertion of your exercise program (circle the number):
   (1) Light (2) Fairly light (3) Somewhat hard (4) Hard

9. How long have you been exercising regularly? _____months _____ years

10. What other exercise, sport, or recreational activities have you participated in?

   a. In the past 6 months? _____

   b. In the past 5 years? _____

11. Can you exercise during your work day?
   ☐ Yes ☐ No

Goal Setting

Goal setting is a major aspect to training. It is important that you set the right goals for yourself. Together you and your trainer will you set the goals that are appropriate for you in order to assure that you get the most out of each session. When choosing goals they should be **S.M.A.R.T.**

Specific-If your goal is weight loss; try to make it more specific. Try stating the amount of weight, the time frame, and the method of measurement (scale or body fat %).
Measurable- To truly evaluate improvements, the goal should be measurable. The way you look is not tangible, reliable measurable.
Attainable- Goals should be challenging but possible. Keep in mind how long you are allowing for reaching your goal and make sure that is safe and realistic.
Relevant- Goals should be pertinent to your interest, needs, and abilities.
Time bound- Set a timeline reaching your goal. Again be realistic.

12. Please rate your exercise goals using the following scale:

Extremely Important				Somewhat Important					Not at all Important
1	2	3	4	5	6	7	8	9	10

   a. Improve cardiovascular fitness _____
   b. Body-fat weight loss _____
   c. Reshape or tone my body _____
   d. Improve performance for a specific sport _____
   e. Improve moods and ability to cope with stress _____
   f. Improve flexibility _____
   g. Increase strength _____
   h. Increase energy level _____
   i. Enjoyment _____
   j. Other _____

15. What specific goal are you looking to reach through group training?_____