



Personal Training Information

Date: _____

Name: _____ Date of Birth: ___/___/___ Age: ___ Weight: ___
D M Y

Mailing Address: _____

Phone: (H) _____ (W) _____ Occupation: _____

My resting heart rate is ___ beats per 60 seconds.

If medical clearance is necessary, I give my permission for Mary Letson to consult with my physician,

Physician's name

Physicians Phone

signature

PAR-Q Form Please mark YES or NO to the following:

Has your doctor ever said that you have a heart condition and that you should only do physical activity that is recommended by a doctor? YES NO

Do you frequently have pains in your chest when you perform physical activity? YES NO

In the past month, have you had chest pain when you were not doing physical activity? YES NO

Do you lose your balance due to dizziness or do you ever lose consciousness? YES NO

Do you have a bone, joint or other problem (diabetes, epilepsy, asthma, back problems) that must be addressed when developing an exercise program? YES NO

Has your doctor told you that you have high/low blood pressure? YES NO

Are you pregnant now or have you given birth within the last 6 months? YES NO

Have you had recent surgery? YES NO

If you marked yes to any of the above, please elaborate: _____

Do you smoke? YES NO How many hours do you sleep at night? ____

How would you rate your Nutrition?(1=poor 10=excellent) ____

Do you take any medications either prescription or non prescription on a regular basis? YES NO

What is the medication and how does this medication affect your ability to exercise?