Your Prescription for Health
ExeRxcise is Medicine®
www.ExerciseisMedicine.org

INFORMED CONSENT

INFORMED CONSENT FOR PARTICIPATION IN A HEALTH AND FITNESS TRAINING PROGRAM

NAME: _____ DATE: _____

1. PURPOSE AND EXPLANATION OF PROCEDURE

I hereby consent to voluntarily engage in an acceptable plan of personal fitness training. I also give consent to be placed in personal fitness training program activities which are recommended to me for improvement of dietary counseling, stress management, and health/fitness education activities. The levels of exercise I perform will be based upon my cardiorespiratory (heart and lungs) and muscular fitness. I understand that I may be required to undergo a graded exercise test prior to the start of my personal fitness training program in order to evaluate and assess my present level of fitness.

I will be given exact personal instructions regarding the amount and kind of exercise I should do. A professionally trained personal fitness trainer will provide leadership to direct my activities, monitor my performance, and otherwise evaluate my effort. Depending upon my health status, I may or may not be required to have my blood pressure and heart rate evaluated during these sessions to regulate my exercise within desired limits. I understand that I am expected to attend every session and to follow staff instructions with regard to exercise, stress management, and other health and fitness regarded programs. If I am taking prescribed medications, I have already so informed the program staff and further agree to so inform them promptly of any changes which my doctor or I have made with regard to use of these. I will be given the opportunity for periodic assessment and evaluation at regular intervals after the start of the program.

I have been informed that during my participation in the above described personal fitness training program, I will be asked to complete the physical activities unless symptoms such as fatigue, shortness of breath, chest discomfort or similar occurrences appear. At this point, I have been advised that it is my complete right to

decrease or stop exercise and that it is my obligation to inform the personal fitness training program personnel of my symptoms, should any develop.

I understand that during the performance of exercise, a personal fitness trainer will periodically monitor my performance and, perhaps measuring my pulse, blood pressure, or assess my feelings of effort for the purposes of monitoring my progress. I also understand that the personal fitness trainer may reduce or stop my exercise

program when any of these findings so indicate that this should be done for my safety and benefit.

I also understand that during the performance of my personal fitness training program physical touching and positioning of my body may be necessary to assess my muscular and bodily reactions to specific exercises, as well as to ensure that I am using proper technique and body alignment. I expressly consent to the physical contact for the stated reasons above.

2. RISKS

It is my understanding and I have been informed that there exists the remote possibility during exercise of adverse changes including, but not limited to, abnormal blood pressure, fainting, dizziness, disorders of heart rhythm, and in very rare instances heart attack, stroke, or even death. I further understand and I have been informed that there exists the risk of bodily injury including, but not limited to, injuries to the muscles, ligaments, tendons, and joints of the body. Every effort, I have been told, will be made to minimize these occurrences by proper staff assessments of my condition before each personal fitness training session, staff supervision during exercise and by my own careful control of exercise efforts. I fully understand the risks associated with exercise, including the risk of bodily injury, heart attack, stroke or even death, but knowing these risks, it is my desire to participate as herein indicated.

3. BENEFITS TO BE EXPECTED AND ALTERNATIVES AVAILABLE TO EXERCISE

I understand that this program may or may not benefit my physical fitness or general health. I recognize that involvement in the personal fitness training sessions will allow me to learn proper ways to perform conditioning exercises, use fitness equipment and regulate physical effort. These experiences should benefit me by indicating how my physical limitations may affect my ability to perform various physical activities. I further understand that if I closely follow the program instructions, that I will likely improve my exercise capacity and fitness level after a period of 3-6 months.

4. CONFIDENTIALITY AND USE OF INFORMATION

I have been informed that the information which is obtained in this personal fitness training program will be treated as privileged and confidential and will consequently not be released or revealed to any person, to the use of any information which is not personally identifiable with me for research and statistical purposes so long as same does not identify my person or provide facts which could lead to my

identification. Any other information obtained, however, will be used only by the program staff to evaluate my exercise status or needs.

5. INQUIRIES AND FREEDOM OF CONSENT

I have been given an opportunity to ask questions as to the procedures.

I have read this Informed Consent form, fully understand its terms, understand that I have given up substantial rights by signing it, and sign it freely and voluntarily, without inducement.

Participant's Signature

_____

Participant's Name (Printed)

_____

Witness's Signature _____ Date: _____

HEALTH AND MEDICAL QUESTIONNAIRE

ANYFITNESS INC

HEALTH & MEDICAL QUESTIONNAIRE

Name: _____ Date of birth: _____
Date: _____

Address:_____
Street City State Zip

Phone (Cell): _____ (Work): _____
Email address: _____

In case of emergency, whom may we contact?

Name: _____ Relationship: _____

Phone (Cell):_____ (Home):_____

Personal physician

Name: _____ Phone: _____
Fax: _____

Present/Past History

Have you had or do you presently have any of the following? (Check if yes.)

_____ Rheumatic fever

_____ Recent operation

_____ Edema (swelling of ankles)

_____ High blood pressure

_____ Low blood pressure

_____ Injury to back or knees

_____ Seizures

_____ Lung disease

_____ Heart attack or known heart disease

_____ Fainting or dizziness

_____ Diabetes

_____ High Cholesterol

_____ Orthopnea (the need to sit up to breathe comfortably) or paroxysmal (sudden, unexpected attack) or nocturnal dyspnea (shortness of breath at night)

_____ Shortness of breath at rest or with mild exertion

_____ Chest pains

_____ Palpitations or tachycardia (unusually strong or rapid beat)

_____ Intermittent claudication (calf cramping)

_____ Pain, discomfort in the chest, neck, jaw, arms, or other areas

_____ Known heart murmur

_____ Unusual fatigue or shortness of breath with usual activities

_____ Temporary loss of visual acuity or speech, or short-term numbness or weakness in one side, arm, or
leg of your body

_____ Cancer

_____ Other (please describe): _____

Family History

Have any of your first-degree relatives (parent, sibling, or child) experienced the following conditions? (Check if yes.) In addition, please identify at what age the condition occurred.

_____ Heart attack

_____ Heart operation (Bypass surgery, Angioplasty, Coronary Stent placement)

_____ Congenital heart disease

_____ High blood pressure

_____ High cholesterol

_____ Diabetes

_____ Other major illness: _____

Explain checked items :

_____
_____
_____
_____

Activity History

1. How were you referred to this program? (Please be specific.)
   _____
2. Why are you enrolling in this program? (Please be specific.)
   _____
3. Have you ever worked with a personal trainer before? Yes _____ No _____
4. Date of your last physical examination performed by a physician:
   _____
5. Do you participate in a regular exercise program at this time?
   Yes _____ No _____ If yes, briefly describe:
   _____
   _____
5. Can you currently walk 4 miles briskly without fatigue? Yes _____ No _____
6. Have you ever performed resistance training exercises in the past?
   Yes _____ No _____
7. Do you have injuries (bone or muscle disabilities) that may interfere with exercising? Yes _____No _____ If yes, briefly describe:
   _____
8. Do you smoke? Yes _____ No _____ If yes, how much per day and what was your age when you started? Amount per day _____ Age _____
9. What is your body weight now? _____What was it one year ago? _____
   At age 21? _____
10. How tall are you? ___
11. Do you follow or have you recently followed any specific dietary intake plan and, in general, how do you feel about your nutritional habits?
    _____
    _____
    _____

12. List the medications you are presently taking.

    _____
    _____
    _____

13. List in order your personal health and fitness objectives.
    a. _____
    b. _____
    c. _____
    d. _____

Thank you.

EXERCISE PRESCRIPTION & REFERRAL FORM

PATIENT'S NAME: _____ DOB: _____ DATE: _____

HEALTH CARE PROVIDER'S NAME: _____ SIGNATURE: _____

PHYSICAL ACTIVITY RECOMMENDATIONS

Type of physical activity:	Aerobic	Strength
Number of days per week:		
Minutes per day:		
Total minutes per week*:		

*PHYSICAL ACTIVITY GUIDELINES

Adults aged 18-64 with no chronic conditions: Minimum of 150 minutes of moderate physical activity a week (for example, 30 minutes per day, five days a week) ***and*** muscle-strengthening activities on two or more days a week (2008 Physical Activity Guidelines for Americans).
For more information, visit www.acsm.org/physicalactivity.

REFERRAL TO HEALTH & FITNESS PROFESSIONAL

Name: _____

Phone: _____

Address: _____

_____

Web Site: _____

Follow-up Appointment Date: _____

Notes: _____

_____

_____

_____

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