



Personal Training Registration Form

Campus Recreation Department: Fitness & Wellness

Contact:
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936-468-6052

Personal Training Policies

Please check that you understand each of the following:

- The client’s personal training packet must be completed and fees must be paid in full at the time of purchase. Failure to do so may result in delayed initial consultation. All forms will be confidential to the client as assigned personal trainer(s).
- A processing fee of \$10 will be charged if patron requests a refund once they have been assigned a personal trainer(s).
- Sessions will expire 6 months after purchasing. Please contact Jescelyn Villarreal at jescelyn.villarreal@sfasu.edu for special considerations.
- Session payments are non-refundable after first session has been completed. Sessions are 60 minutes in length starting at your scheduled time. If you are more than 15 minutes late, it will be considered a *No Show* and the session will be charged. You must call your personal trainer with cancellations at least 12 hours in advance before the session in order to reschedule.
- All clients must abide by Campus Recreation facility policies and guidelines.

By typing my name below, I am stating that I have read, understand, and will abide by these policies

Type Name: _____ Date: _____

New Client Data Questionnaire

Name (Last, First): _____

E-mail: _____ Phone: _____

Address: _____ City: _____ State/Zip: _____

Select One: New Client Renewal

Trainer Preference: Male Female No Preference

**If you would like to work with a particular Trainer, please indicate their name: _____

PT Program Type (select one): In-person (at the SRC) Virtual

Date of Birth: ____/____/____ Age: _____

Height: _____ Weight: _____

Emergency Contact: _____ Relationship _____ Phone: _____

Physician’s Name: _____ Physician Phone #: _____

Please pick the classification that best describes you:

Student: Freshman Sophomore Junior Senior Graduate

~OR~

Campus Rec Member: Staff Faculty SFASU Alumni Post Baccalaureate Dependent

Sex M F X

Residence On Campus Housing Nacogdoches Other

Ethnicity American Indian or Alaskan Native Asian or Pacific Islander
White Black or African American
Hispanic or Mexican American Other, please specify _____

How did you hear about our Personal Training Services?

Website Friend Rec Center Social Media Other: _____

Please indicate times you are available to work with a trainer:

Day	Time
Monday	
Tuesday	
Wednesday	
Thursday	
Friday	
Saturday	
Sunday	

Physical

By how much would you like to change your current weight?

(+) _____ lbs (-) _____ lbs

In the past year, how often have you engaged in physical activity?

Regularly (3-4 times/week) Semi Regularly (1-2 times/week)
Sporadic (1-2 times/month) None

How long have you been exercising regularly (months/years)?: _____

When you exercise, rate your perceived exertion:

Light Fairly Light Somewhat Hard Hard

Do you start exercise programs but then find yourself unable to stick to them?

Yes No

What are your personal barriers for not exercising or sticking to a program?

What types of exercise interest you? (please check all that apply)

cardiovascular machines abdominal strength exercises
 running/walking program weight machines
 free weights flexibility
 sport skills group exercise classes
 mind/body other: _____

How much time are you willing to dedicate to an exercise program?

_____ minutes/day _____ days/week

Rank your goals in undertaking exercise: Use the following scale to rate each goal separately.

Extremely important Somewhat important Not at all important
 1 – 4 5 – 7 8 – 10

Goal	
Improve Cardiovascular Fitness	
Body-fat weight loss	
Reshape or tone my body	
Improve performance for a specific sport	
Improve moods and ability to cope with stress	
Improve flexibility	
Increase strength	
Increase energy level	
Feel better	
Enjoyment	
Other	

Please list any other comments regarding your goals with starting a personal training service:

Dietary

How many meals and/or snacks do you have per day?:

What would you estimate your caloric intake to be per day:

Do you feel you eat healthy “most of the time”?

Is your diet well balanced (including vegetables, fruits, breads, cereals, dairy products, and adequate sources of protein)? Yes No

Stress/Social

How do you deal with stress normally?

Do you hold in your angry feelings without expressing them?

Yes No

Do you have at least one person whom you can discuss personal concerns, worries, or problems with?

Yes No

If you answered yes to #3, do they make you feel respected and/or admired? Yes No

Are you satisfied with the support you provide to others? Yes No

Indicate how you are dealing with daily stress:

Indicate your energy level:

How many hours of sleep do you normally get?

Occupational

What is your present occupation?:

What type of activity does your occupation require (walking, getting up and down, carrying things)?

What are your usual leisure activities?

Expectations

Why have you decided to begin or improve your exercise program?

Specifically describe what you would like to accomplish through your fitness program during the next

1 month:

4 months:

1 year:

What are you looking forward to most about starting a personal training program?

Medical

Please indicate whether you **CURRENTLY HAVE** or **PREVIOUSLY HAVE HAD** a significant problem with any of the symptoms or conditions listed below:

****Please assess your health status with true statements*

<u>History</u>	Yes	No	Don't Know	Comments/details/year
Heart attack				
Heart surgery				

Heart failure				
Heart transplantation				
Heart valve disease				
Stroke				
Cancer				

<u>Signs & Symptoms</u>	Yes	No	Don't Know	Comments/details/year
Pain, discomfort, tightness in chest, neck, jaw or arms				
Chest pain with exertion				
Shortness of breath at rest or with mild exertion				
Fainting, dizziness, or blackouts				
Unusual shortness of breath or fatigue with usual activities				

<u>Other</u>	Yes	No	Don't Know	Comments/details/year
Diabetes				
Exercise-induced Asthma				
Bone, joint, or muscular injury				
Arthritis				
Eating disorder				
Pregnancy				

<u>Major Risk Factors</u>	Yes	No	Don't Know	Comments/details/year
Body Mass Index ≥ 30 or a waist girth >100 cm (39.3 in.)				
Father or brother experienced a heart attack before the age of 55				
Mother or sister experienced a heart attack before the age of 65?				
Smoke, or have quit in last 6 months				
High blood pressure ($>140/90$ mmHg)				
High blood cholesterol (>200 mg/dl)				

If you answered "yes" to any of these questions, call your personal physician or healthcare provider before increasing your physical activity level.

Medications/Vitamins

Please list current medications/vitamins/supplements including over-the-counter medications, prescriptions, etc. (please indicate the name, dosage, purpose and duration of each item)

Known allergies (*Environmental, Medications, Food, Etc.*)

Family History

Please indicate if any family member has had any of the following:

Medical Condition	Yes	No	Relationship to you / Comments
Obesity			
Heart Attack			
Stroke			
Cardiovascular Disease			
High Blood Pressure			
High Cholesterol			
Diabetes			
Cancer			
Osteoporosis			

Please list any other conditions that your family members may have that you feel are pertinent for Personal Training staff to know for your training:

Personal Training: For Office Use Only

	2 Sessions	5 Sessions	10 Sessions	15 Sessions
Member	<input type="checkbox"/> \$60	<input type="checkbox"/> \$125	<input type="checkbox"/> \$225	<input type="checkbox"/> \$320
Non-Member	<input type="checkbox"/> \$80	<input type="checkbox"/> \$175	<input type="checkbox"/> \$300	<input type="checkbox"/> \$450
Partner	<input type="checkbox"/> \$40	<input type="checkbox"/> \$90	<input type="checkbox"/> \$150	<input type="checkbox"/> \$225
Partner (NM)	<input type="checkbox"/> \$60	<input type="checkbox"/> \$140	<input type="checkbox"/> \$250	<input type="checkbox"/> \$375

Promotion/Special:

_____ Sessions = \$ _____

Partner Names: _____

*Remember that Weight Room Orientation, Fitness Assessment and Body Composition are included in session purchases.

Weight Room Orientation (Free) **Fitness Assessment (\$15)** **Body Composition Test (\$5)**

Form of Payment: *(please circle)* Credit Card/Debit Card Check (#) _____ Cash Gift Certificate

Total \$ _____ **Staff Initial:** _____ **Invoice #** _____

Thank you for your purchase of a personal training package.
We look forward to working with you!



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