



PERSONAL TRAINING REQUEST



Thank you for your interest in working with a Fitness and Wellness Center Personal Trainer. Please complete these forms and return them to the Front Desk. We understand you are eager to meet with a Trainer as soon as possible, however, after a review of your Health History Questionnaire you may be asked to have your physician complete a Medical Clearance Form. We will gladly fax this form directly to your physician in order to expedite the process.

NAME	EMAIL
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ADDRESS	CITY	STATE	ZIP CODE
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CELL PHONE	HOME PHONE	WORK PHONE
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I WOULD LIKE TO HIRE A TRAINER BECAUSE MY MAIN GOAL(S) IS/ARE:

***OUR TRAINERS HAVE EXPERIENCE WORKING WITH DIVERSE POPULATIONS AND ATHLETES. GOALS CAN INCLUDE: A FITNESS ASSESSMENT, A WEIGHTLIFTING PROGRAM FOR YOU, A SPORTS SPECIFIC TRAINING PROGRAM, A COMPLETE FITNESS PROGRAM, A REHAB AFTER INJURY PROGRAM, A BEGINNER'S WORKOUT, AQUATICS WORKOUTS, WEIGHT LOSS PROGRAMS, FUNCTIONAL WORKOUTS AND ADVANCED PARTICIPANT PROGRAMS.*

I AM INTERESTED IN: (Circle one)	INDIVIDUAL SESSIONS	SEMI-PRIVATE SESSIONS	GROUP SESSIONS	OTHER:
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I WOULD LIKE TO BOOK	60 MINUTE SESSIONS	30 MINUTE SESSIONS	OTHER:
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Mount Wachusett
Community College

FITNESS & WELLNESS CENTER

**444 GREEN STREET
GARDNER, MA 01440**

(978) 630-9212 FRONT DESK
(978) 630-9562 FAX

mwcc.edu/fitness

CLIENTS MAY REQUEST A SPECIFIC TRAINER. WHEN THERE IS NO REQUEST WE ASSIGN CLIENTS TO TRAINERS BASED ON CLIENT GOALS, TRAINER EXPERIENCE AND MATCHING AVAILABILITY.

I WOULD LIKE TO REQUEST:
(Trainer Name)

I AM AVAILABLE TO MEET WITH A TRAINER ON THE FOLLOWING DAYS/TIMES:

DAY	TIME FROM 0:00 AM/PM	UNTIL 0:00 AM/PM
SUNDAY		
MONDAY		
TUESDAY		
WEDNESDAY		
THURSDAY		
FRIDAY		
SATURDAY		



PERSONAL TRAINING POLICY ACKNOWLEDGEMENT AND PARTICIPATION WAIVER



I have read the Fitness and Wellness Center Personal Training Policies and I agree to abide by the terms and conditions set forth in them. _____ INITIAL

I declare myself to be physically sound and suffering from no condition, impairment, disease, infirmity or other illness that would prevent my participation in a Personal Training Program. I declare that the information contained in my Health History form to be accurate and complete, without omissions. _____ INITIAL

I understand that I am choosing to participate in a program of progressive physical activity and that strength training, cardiovascular training, aerobic exercise and all fitness related activities, including the use of equipment and machinery, are potentially hazardous activities. I understand that progressive physical activity and fitness activities involve a risk of injury and even death and that I declare that I am voluntarily participating in these activities and using equipment and machinery with a knowledge of the dangers involved. I hereby agree to expressly assume and accept any and all risks of injury or death. _____ INITIAL

I understand that it is recommended that I seek my physician's approval prior to beginning a Personal Training Program. I acknowledge that either I have had a physical examination and I have my physician's approval to participate or that I have decided to participate in a Personal Training Program without the approval of my physician and I do hereby assume all responsibility for my participation, activities and use of equipment or machinery in my activities. _____ INITIAL

I hereby agree that all of the activities in which I participate during the course of my Personal Training Program will be undertaken by me at my sole risk and that Mount Wachusett Community College shall not be liable to me or anyone claiming through me for any claims, demands, injuries, damages, actions of causes of actions whatsoever, to my person or property or arising out of such activities or arising out of or in connection with my use of the College facilities. I hereby and expressly and forever release and discharge Mount Wachusett Community College, its officers, servants, agents, students or employees from and with respect to any loss, claims, demands, injuries, damages or liability caused by their negligence while on or using the Colleges facilities. I further certify that I have sufficient medical and hospital insurance to cover any medical treatment that may be necessitated by injuries sustained while on College property and recognize that the College has relied on this representation in approving my request to participate in Personal Training. _____ INITIAL

SIGNATURE OF CLIENT:

DATE:

CLIENT NAME PRINTED:

RELATIONSHIP TO CLIENT (PARENT OR LEGAL GUARDIAN) FOR PARTICIPANTS UNDER 18:

PARENT/LEGAL GUARDIAN PRINTED NAME

SIGNATURE OF PARENT OR LEGAL GUARDIAN:

DATE:



Fitness and Wellness Center
 444 Green Street, Gardner MA 01440
 (978) 630-9212 Front Desk
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 mwcc.mass.edu/fitness

HEALTH HISTORY QUESTIONNAIRE

Instructions: Regular physical activity is safe for most people however, some individuals should check with their doctor before they start an exercise program. To help us determine if you should consult with your doctor before exercising at the Fitness and Wellness Center, please complete this Questionnaire. All information will be kept confidential.

NAME		EMAIL	
ADDRESS			
CITY		STATE	ZIP
HOME PHONE		BIRTHDATE	AGE
CELL PHONE		GENDER (Circle one) MALE FEMALE TRANS	
WORK PHONE		HEIGHT	WEIGHT

Please answer the following questions about your health and health history: **Circle your answer**

1	Do you have a heart condition?	yes	no
2	Have you ever experienced a stroke?	yes	no
3	Do you have epilepsy?	yes	no
4	Are you pregnant?	yes	no
5	Do you have emphysema/COPD?	yes	no
6	Do you have diabetes?	yes	no
7	Do you feel pain in the chest when you participate in physical activity?	yes	no
8	Do you have chronic bronchitis?	yes	no
9	In the past month, have you had chest pain when you were not doing physical activity?	yes	no
10	Do you ever lose consciousness?	yes	no
11	Do you ever lose control of your balance due to chronic dizziness?	yes	no
12	Has a physician ever told you or are you aware that you have high blood pressure?	yes	no
13	Has anyone in your immediate family had a heart attack, heart disease or stroke before age 55?	yes	no
14	Has a physician ever told you or are you aware that you have a high cholesterol level?	yes	no
15	Do you currently smoke?	yes	no
16	Are you a male over 44 years of age?	yes	no
17	Are you a female over 54 years of age?	yes	no
18	Are you currently being treated for OR have you ever had a bone or joint problem that restricts you from engaging in physical activity? If YES, please describe:	yes	no
19	Are you currently taking any medication? Please list the medication and its purpose:	yes	no
20	Are you currently exercising LESS than 1 hour per week? If you answered NO, please list your activities:	yes	no

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21	What are your specific fitness goals at the Fitness and Wellness Center? Check all that apply:		
	Increase strength and endurance		Improve flexibility
	Improve cardiovascular fitness		Improve muscle tone
	Reduce body fat		Increase muscle mass
	Exercise regularly		Injury rehabilitation
	Sports conditioning		Other:

22	What are your specific health goals at the Fitness and Wellness Center? Check all that apply:		
	Reduce stress		Improve nutritional habits
	Control blood pressure		Control cholesterol
	Stop smoking		Achieve balance in life
	Improve productivity		Reduce back pain
	Feel better overall		Increase my health awareness
	Other:		

23 Please use this section for any additional health history or information you think will help your trainer design a program for you:

I have read and understood this Health History Questionnaire. My answers comprehensively describe my health history and current level of health and fitness.

SIGNATURE OF CLIENT: _____ **DATE:** _____

CLIENT NAME PRINTED: _____

RELATIONSHIP TO CLIENT (PARENT OR LEGAL GUARDIAN) FOR PARTICIPANTS UNDER 18:	PARENT/LEGAL GUARDIAN PRINTED NAME
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SIGNATURE OF PARENT OR LEGAL GUARDIAN: _____

DATE: _____