FOR YOUTH DEVELOPMENT
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

Personal Training Prospect Screening

Border View Family YMCA

Name: ____ DOB: _______________ Date: __________

Address: ____________________________________ E-Mail: ______________________________

Home #: ___________________Work #: ___________________ Cell #: ____________________

Trainer Preferred: __________________________________ Male or Female Trainer (Circle one)

Days of the Week: _________________________________ # of Sessions wanted: ___________

Workout Time: ______________________ Health Conditions: __________________________

Goals: ____

YES	NO	***QUESTIONS*** **Ages 15 to 69 years need physician clearance if YES to one or more questions. Over age 69 needs initial physician clearance before exercising.**
		Has your doctor ever said that you have a heart condition and that you should only do physical activities recommended by a doctor?
		Do you feel pain in your chest when you do physical activity?
		In the past month, have you had chest pain when you were not doing physical activity?
		Do you lose balance because of dizziness or do you ever lose consciousness?
		Do you have a bone or joint problem that could be made worse by a change in your physical activity?
		Is your doctor currently prescribing drugs (for example, water pills) for your blood pressure or heart condition?
		Are you under a doctor's care for cardiac (cardiac, stroke), pulmonary (COPD, Asthma) or metabolic disease (Diabetes, thyroid, kidney or liver disease)?
		Do you know of any reason why you should not do physical activity?

Referred to: ______________________________________

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PLEASE CALL CLIENT WITHIN 24 HOURS OF RECEIVING SCREENING SHEET AND RETURN THE FOLLOWING TO THE HEALTH & FITNESS DIRECTOR:

Client Name: ____ Date Called: _____________

YES: ___ the client and I are scheduled to start __________________

NO: ___I am not able to schedule this client please refer to another trainer.

Trainer Signature: ____ Date: ___________