NEW ORLEANS

PERSONAL TRAINING INQUIRY FORM

MEMBER NAME	MEMBER PHONE
MEMBER EMAIL	DATE

TRAINING PREFERENCES (CIRCLE PREFERENCES)

TRAINER GENDER MALE FEMALE NO PREFERENCE

SESSION TIME MORNING AFTERNOON EVENING ANYTIME

OR

SPECIFIC TIME AM 6:00 7:00 8:00 9:00 10:00 11:00

PM 12:00 1:00 2:00 3:00 4:00 5:00 6:00 7:00 8:00

SPECIFIC DAY MON TUES WED THURS FRI SAT SUN

I PREFER TO TRAIN WITH (NAME OF TRAINER) _____

ADDITIONAL INFORMATION _____

_____

_____

CONTRACT INFORMATION

All personal training packages have an expiration date: 1, 3 and 6 sessions expire 3 months from the date of purchase; 10 and 20 sessions expire 6 months from the date of purchase.

ll sessions require a 24-hour cancellation notice or the client will be charged for the session.

Personal training sessions are nontransferable and nonrefundable.

CLIENT SIGNATURE	DATE

MEDICAL HISTORY CHECK ALL THAT APPLY

- ☐ Recent illness, hospitalization or surgical procedure
- ☐ Heart attack, coronary bypass, cardiac surgery, stroke
- ☐ Abnormal resting or stress ECG
- ☐ Uneven, irregular, or skipped heart beats (including a racing or fluttering heart)
- ☐ Abnormal blood lipids (total cholesterol, HDL, LDL, triglycerides)
- ☐ Family history of coronary or other atherosclerotic disease before age 55 male/65 female
- ☐ Diabetes Mellitus (type I, type II, or gestational)
- ☐ High blood pressure
- ☐ Phlebitis Emboli
- ☐ Pulmonary disease (asthma, emphysema, and bronchitis)
- ☐ Light-headedness or fainting
- ☐ Chest pain at rest or exertion
- ☐ Unusual shortness of breath
- ☐ Orthopedic problems (arthritis or any other bone, joint, or muscle problems)
- ☐ Emotional disorders
- ☐ Medications
- ☐ Drug allergies
- ☐ Smoking
- ☐ Physical inactivity

Are you under the care of a physician, chiropractor or other health professional for any reason?

IF YES, LIST REASON:

MEDICAL RELEASE

If I check one or more of the answers above, I agree to provide either a medical release from my physician and/or provide my physician's name and contact information in order for our personal training director to obtain the medical release.

With the contact information I have provided, I authorize the New Orleans Jewish Community Center to contact my physician to obtain medical release for personal training.

PHYSICIAN NAME	PHYSICIAN PHONE
MEMBER SIGNATURE	DATE

FOR STAFF USE ONLY

RECOMMENDATIONS/HEALTH STATUS CLASSIFICATION:

- ☐ Medical Clearance
- ☐ Increased Risk
- ☐ Known Disease
- ☐ Refer to medically supervised program
- ☐ Max stress test and medical clearance

STAFF SIGNATURE	DATE