Client Registration Packet may be completed and submitted to appropriate Fitness Coordinator prior to first session or submitted to the assigned Trainer at first session.

New clients must purchase first session prior to scheduling.

South Suburban
PARKS AND RECREATION

Personal Training and

Private Instruction

Client Registration

-Confidential-

South Suburban Personal Training and Private Instruction Services Summary and Costs

Rates	Resident	Non-Resident	Resident	Non-Resident
Adult Personal Training, Yoga, Tai Chi & Mat Pilates	**One on One Hourly**		**Group (2-4) Hourly**	
1 Session	**$45**	**$55**	**$59**	**$70**
3 Sessions	**$126**	**$159**	**$168**	**$201**
5 Sessions	**$200**	**$255**	**$270**	**$325**
10 Sessions	**$380**	**$490**	**$520**	**$630**
Other Personal Training and Private Instruction	**Youth Personal Training (Ages 10-17)**		**Pilates Private Reformer**	
1 Session	**$40**	**$49**	**$50**	**$61**
3 Sessions	**$111**	**$132**	**$141**	**$174**
5 Sessions	**$175**	**$210**	**$225**	**$280**
10 Sessions	**$330**	**$400**	**$430**	**$540**

Personal Training and Private Instruction Information

Please Read Carefully

Personal Training and Private Instruction Policies

In order to help make your experience a positive one, we ask that you observe the following policies:

1. Client Registration Packet must be completed prior to first session or during first session. It is recommended to complete in advance.
2. New clients must purchase sessions prior to the first scheduled session.
3. Trainers cannot take session payments. Please pay for sessions at the Recreation Center Entry or Registration Desk.
4. Call the recreation center of your scheduled session if you know you will be late (Trainers will wait 15 minutes, and then that scheduled session will be forfeited). **If you are late, the session will only last until the end of the hour for which that session was scheduled.**
5. **If needed, sessions must be rescheduled 24 hours in advance or session will be forfeited. Call your Trainer or the Recreation Center front desk to leave a message for your Trainer.**
6. Be ready to work hard during each session; wear athletic type shoes and clothing; bring a towel and water bottle.

Client Confidentiality

Information will not be released without the individual's permission, except in emergency situations. Client registration packet will remain in South Suburban Parks and Recreation files for 7 years following the cessation of your participation in the program.

Regular evaluation of your Trainer's performance and your progress will be completed using written and verbal communication with your Trainer and our fitness staff. If you have any feedback regarding your Trainer or the program, please contact the Buck Fitness Coordinator at (303) 730-4610, Goodson and Sheridan Personal Trainer Coordinator at (303) 483-7089 or the Lone Tree Fitness Coordinator at (303) 708-3514.

Personal Information

Name: _____ DOB/Age: _____

Gender: M F Height: _____ Weight: _____

Current Information

Address: _____ Daytime Phone: _____

City: _____ State: _____ Zip: _____ Evening Phone: _____

Email: _____

Emergency Contact Information

Name: _____ Relation: _____

Home Phone: _____ Work Phone: _____

How did you learn about the South Suburban Personal Training and Private Instruction Services?

_____ Recreation Brochure _____ Recreation Flyer _____ Friend

_____ Recreation Website _____ Other (please explain)_____

Training Preferences and Availability *(Bios are available by visiting www.ssprd.org and selecting the appropriate facility.)*

My preferred Trainer is: _____

I would prefer to train at the following location:

Douglas H. Buck Community Center (2004 W. Powers Ave, Littleton): _____
Goodson Recreation Center (6315 S. University Blvd, Centennial): _____
Lone Tree Recreation Center (10249 Ridgegate Circle, Lone Tree): _____
Sheridan Recreation Center (3325 W Oxford Ave, Denver): _____

Please indicate the days and times you are available and prefer to train. (Please be specific, the more flexible your time the easier to match a Trainer.)

Monday: _____ Thursday: _____ Saturday: _____

Tuesday: _____ Friday: _____ Sunday: _____

Wednesday: _____

Please indicate your current levels of satisfaction:

	Very Dissatisfied						Satisfied			Very Satisfied
Weight	1	2	3	4	5	6	7	8	9	10
Body Composition	1	2	3	4	5	6	7	8	9	10
Physical Activity Level	1	2	3	4	5	6	7	8	9	10
Use of Tobacco Products	1	2	3	4	5	6	7	8	9	10
Blood Pressure & Cholesterol	1	2	3	4	5	6	7	8	9	10
Muscular Strength & Endurance	1	2	3	4	5	6	7	8	9	10
Cardiovascular Endurance	1	2	3	4	5	6	7	8	9	10
Stress Levels	1	2	3	4	5	6	7	8	9	10
Nutrition & Eating Habits	1	2	3	4	5	6	7	8	9	10
General Health & Lifestyle	1	2	3	4	5	6	7	8	9	10

What goals would you like to achieve from participating in services? _____

_____

_____

_____

_____

Medications/Allergies:

Please list any medical concerns/conditions that might limit your ability to participate in services (pregnancy, disability, chronic conditions, etc.):

_____
_____
_____

Please list any known allergies (environmental, medications, food, etc.):

_____
_____

Please list current medications including over-the-counter medications, prescriptions, etc. that may affect your body's response to exercise.

Medication	Dosage	For What?

Exercise History and Attitude:

1. Have you been involved in a routine of regular aerobic exercise (moderate, continuous activity for at least 15-20 minutes duration, at least 3 days per week)? ____yes ____no
   If yes, for how long and what activities? _____
   If no, when was the last time you can recall being active for at least 20 minutes? What activity were you doing?
   _____

2. Are you currently involved in a weight training and conditioning program? ____yes ____no
   Min/Day _____ Days/Week_____
   If yes, please explain/summarize your current program (exercises, free weights, goals, etc…)
   _____
   _____

3. Check the activities you would consider doing and circle the activities you consider "fun."
   ____Walking ____Rowing ____Group Fit Classes ____Strength Training ____Athletic Drills
   ____Swimming ____Jogging ____Cycling ____Cardio Machines
   Other activities you are interested in? _____

4. How much time are you planning to devote to a fitness regimen?

   On your own time: _____days/week _____minutes/day

   Meeting with a Trainer: _____days/week

Informed Consent

South Suburban
PARKS AND RECREATION

I, _____, understand participation in recreation activities and services may have an element of hazard or inherent danger, and users take full responsibility for their actions and physical condition. Users agree to indemnify and hold harmless the South Suburban Parks and Recreation District and its employees and agents for any liability, loss, cost or expense (including attorney's fees, medical, ambulance cost) that users may incur while participating in any Parks and Recreation activities.

Before meeting with a South Suburban Parks and Recreation Trainer, taking part in fitness testing, or engaging in a training program, I certify that I have answered all health and fitness questions honestly and to the best of my ability. I understand the importance of providing complete and accurate responses. I recognize that my failure to do so could lead to possible unnecessary injury to myself during fitness testing and/or exercise programs. I understand that I may have to provide a medical clearance from my doctor prior to participating in any South Suburban Parks and Recreation personal training or private instruction services.

Signature: _____ Date: _____

Guardian Signature: _____ Date: _____
(Required if participant is under the age of 18)

Terms & Conditions

I agree to adhere to all South Suburban Parks and Recreation District's personal training and private instruction policies and procedures.

Initial

_____ Full payment is due prior to services being received and payment cannot be accepted by the Trainer.

_____ If I need to cancel an appointment, I must call the appropriate Recreation Center or my Trainer at least 24 hours prior to my scheduled session/appointment. If I do not call 24 hours prior, that session will be forfeited, including first time sessions.

_____ If I am late (<15 min), the session will only last until the end of the hour for which that session was scheduled. If I am more than 15 minutes late the scheduled session will be forfeited.

_____ If my health status changes after completing the registration packet, I will inform my Trainer immediately. I understand that I may need to obtain physician's clearance prior to continuing training sessions.

Signature: _____ Date: _____

Guardian Signature: _____ Date: _____
(Required if participant is under the age of 18)

PAR-Q+

The Physical Activity Readiness Questionnaire for Everyone

Regular physical activity is fun and healthy, and more people should become more physically active every day of the week. Being more physically active is very safe for MOST people. This questionnaire will tell you whether it is necessary for you to seek further advice from your doctor OR a qualified exercise professional before becoming more physically active.

SECTION 1 - GENERAL HEALTH

	Please read the 7 questions below carefully and answer each one honestly: check YES or NO.	YES	NO
1.	Has your doctor ever said that you have a heart condition OR high blood pressure?	☐	☐
2.	Do you feel pain in your chest at rest, during your daily activities of living, OR when you do physical activity?	☐	☐
3.	Do you lose balance because of dizziness OR have you lost consciousness in the last 12 months? Please answer NO if your dizziness was associated with over-breathing (including during vigorous exercise).	☐	☐
4.	Have you ever been diagnosed with another chronic medical condition (other than heart disease or high blood pressure)?	☐	☐
5.	Are you currently taking prescribed medications for a chronic medical condition?	☐	☐
6.	Do you have a bone or joint problem that could be made worse by becoming more physically active? Please answer NO if you had a joint problem in the past, but it does not limit your current ability to be physically active. For example, knee, ankle, shoulder or other.	☐	☐
7.	Has your doctor ever said that you should only do medically supervised physical activity?	☐	☐

If you answered NO to all of the questions above, you are cleared for physical activity.

Go to Section 3 to sign the form. You do not need to complete Section 2.

- Start becoming much more physically active – start slowly and build up gradually.
- Follow the Canadian Physical Activity Guidelines for your age (www.csep.ca/guidelines).
- You may take part in a health and fitness appraisal.
- If you have any further questions, contact a qualified exercise professional such as a CSEP Certified Exercise Physiologist® (CSEP-CEP).
- If you are over the age of 45 yrs. and NOT accustomed to regular vigorous physical activity, please consult a qualified exercise professional (CSEP-CEP) before engaging in maximal effort exercise.

If you answered YES to one or more of the questions above, please GO TO SECTION 2.

Delay becoming more active if:

- You are not feeling well because of a temporary illness such as a cold or fever – wait until you feel better
- You are pregnant – talk to your health care practitioner, your physician, a qualified exercise professional, and/or complete the PARmed-X for Pregnancy before becoming more physically active OR
- Your health changes – please answer the questions on Section 2 of this document and/or talk to your doctor or qualified exercise professional (CSEP-CEP) before continuing with any physical activity programme.

SECTION 2 - CHRONIC MEDICAL CONDITIONS

			YES	NO
	Please read the questions below carefully and answer each one honestly: check YES or NO.			
1.	Do you have Arthritis, Osteoporosis, or Back Problems?		☐ If yes, answer questions 1a-1c	☐ If no, go to question 2
	1a.	Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer NO if you are not currently taking medications or other treatments)	☐	☐
	1b.	Do you have joint problems causing pain, a recent fracture or fracture caused by osteoporosis or cancer, displaced vertebra (e.g., spondylolisthesis), and/ or spondylolysis/pars defect (a crack in the bony ring on the back of the spinal column)?	☐	☐
	1c.	Have you had steroid injections or taken steroid tablets regularly for more than 3 months?	☐	☐
2.	Do you have Cancer of any kind?		☐ If yes, answer questions 2a-2b	☐ If no, go to question 3
	2a.	Does your cancer diagnosis include any of the following types: lung/bronchogenic, multiple myeloma (cancer of plasma cells), head, and neck?	☐	☐
	2b.	Are you currently receiving cancer therapy (such as chemotherapy or radiotherapy)?	☐	☐
3.	Do you have Heart Disease or Cardiovascular Disease? This includes Coronary Artery Disease, High Blood Pressure, Heart Failure, Diagnosed Abnormality of Heart Rhythm		☐ If yes, answer questions 3a-3e	☐ If no, go to question 4
	3a.	Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer NO if you are not currently taking medications or other treatments)	☐	☐
	3b.	Do you have an irregular heart beat that requires medical management? (e.g. atrial brillation, premature ventricular contraction)	☐	☐
	3c.	Do you have chronic heart failure?	☐	☐
	3d.	Do you have a resting blood pressure equal to or greater than 160/90 mmHg with or without medication? (Answer YES if you do not know your resting blood pressure)	☐	☐
	3e.	Do you have diagnosed coronary artery (cardiovascular) disease and have not participated in regular physical activity in the last 2 months?	☐	☐
4.	Do you have any Metabolic Conditions? This includes Type 1 Diabetes, Type 2 Diabetes, Pre-Diabetes		☐ If yes, answer questions 4a-4c	☐ If no, go to question 5
	4a.	Is your blood sugar often above 13.0 mmol/L? (Answer YES if you are not sure)	☐	☐
	4b.	Do you have any signs or symptoms of diabetes complications such as heart or vascular disease and/or complications affecting your eyes, kidneys, and the sensation in your toes and feet?	☐	☐
	4c.	Do you have other metabolic conditions (such as thyroid disorders, pregnancy-related diabetes, chronic kidney disease, liver problems)?	☐	☐
5.	Do you have any Mental Health Problems or Learning Difficulties? This includes Alzheimer's, Dementia, Depression, Anxiety Disorder, Eating Disorder, Psychotic Disorder, Intellectual Disability, Down Syndrome)		☐ If yes, answer questions 5a-5b	☐ If no, go to question 6
	5a.	Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer NO if you are not currently taking medications or other treatments)	☐	☐
	5b.	Do you also have back problems affecting nerves or muscles?	☐	☐

Please read the questions below carefully and answer each one honestly: check YES or NO.			YES	NO
6.	Do you have a Respiratory Disease? This includes Chronic Obstructive Pulmonary Disease, Asthma, Pulmonary High Blood Pressure		☐ If yes, answer questions 6a-6d	☐ If no, go to question 7
	6a.	Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer NO if you are not currently taking medications or other treatments)	☐	☐
	6b.	Has your doctor ever said your blood oxygen level is low at rest or during exercise and/or that you require supplemental oxygen therapy?	☐	☐
	6c.	If asthmatic, do you currently have symptoms of chest tightness, wheezing, laboured breathing, consistent cough (more than 2 days/week), or have you used your rescue medication more than twice in the last week?	☐	☐
	6d.	Has your doctor ever said you have high blood pressure in the blood vessels of your lungs?	☐	☐
7.	Do you have a Spinal Cord Injury? This includes Tetraplegia and Paraplegia		☐ If yes, answer questions 7a-7c	☐ If no, go to question 8
	7a.	Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer NO if you are not currently taking medications or other treatments)	☐	☐
	7b.	Do you commonly exhibit low resting blood pressure significant enough to cause dizziness, light-headedness, and/or fainting?	☐	☐
	7c.	Has your physician indicated that you exhibit sudden bouts of high blood pressure (known as Autonomic Dysreflexia)?	☐	☐
8.	Have you had a Stroke? This includes Transient Ischemic Attack (TIA) or Cerebrovascular Event		☐ If yes, answer questions 8a-c	☐ If no, go to question 9
	8a.	Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer NO if you are not currently taking medications or other treatments)	☐	☐
	8b.	Do you have any impairment in walking or mobility?	☐	☐
	8c.	Have you experienced a stroke or impairment in nerves or muscles in the past 6 months?	☐	☐
9.	Do you have any other medical condition not listed above or do you live with two chronic conditions?		☐ If yes, answer questions 9a-c	☐ If no, read the advice on page 4
	9a.	Have you experienced a blackout, fainted, or lost consciousness as a result of a head injury within the last 12 months OR have you had a diagnosed concussion within the last 12 months?	☐	☐
	9b.	Do you have a medical condition that is not listed (such as epilepsy, neurological conditions, kidney problems)?	☐	☐
	9c.	Do you currently live with two chronic conditions?	☐	☐

Please proceed to Page 4 for recommendations for your current medical condition and sign this document.

PAR-Q+

If you answered NO to all of the follow-up questions about your medical condition, you are ready to become more physically active:

- It is advised that you consult a qualified exercise professional (e.g., a CSEP-CEP) to help you develop a safe and effective physical activity plan to meet your health needs.
- You are encouraged to start slowly and build up gradually – 20-60 min. of low- to moderate-intensity exercise, 3-5 days per week including aerobic and muscle strengthening exercises.
- As you progress, you should aim to accumulate 150 minutes or more of moderate-intensity physical activity per week.
- If you are over the age of 45 yrs. and NOT accustomed to regular vigorous physical activity, please consult a qualified exercise professional (CSEP-CEP) before engaging in maximal effort exercise.

If you answered YES to one or more of the follow-up questions about your medical condition:

- You should seek further information from a licensed health care professional before becoming more physically active or engaging in a fitness appraisal.

Delay becoming more active if:

- You are not feeling well because of a temporary illness such as a cold or fever – wait until you feel better
- You are pregnant - talk to your health care practitioner, your physician, a qualified exercise profesional, and/or complete the PARmed-X for Pregnancy before becoming more physically active OR
- Your health changes - please talk to your doctor or qualified exercise professional (CSEP-CEP) before continuing with any physical activity programme.

SECTION 3 - DECLARATION

- You are encouraged to photocopy the PAR-Q+. You must use the entire questionnaire and NO changes are permitted.
- The Canadian Society for Exercise Physiology, the PAR-Q+ Collaboration, and their agents assume no liability for persons who undertake physical activity. If in doubt after completing the questionnaire, consult your doctor prior to physical activity.
- If you are less than the legal age required for consent or require the assent of a care provider, your parent, guardian or care provider must also sign this form.
- Please read and sign the declaration below:

I, the undersigned, have read, understood to my full satisfaction and completed this questionnaire. I acknowledge that this physical activity clearance is valid for a maximum of 12 months from the date it is completed and becomes invalid if my condition changes. I also acknowledge that a Trustee (such as my employer, community/fitness centre, health care provider, or other designate) may retain a copy of this form for their records. In these instances, the Trustee will be required to adhere to local, national, and international guidelines regarding the storage of personal health information ensuring that they maintain the privacy of the information and do not misuse or wrongfully disclose such information.

NAME _____ DATE _____

SIGNATURE _____WITNESS _____

SIGNATURE OF PARENT/GUARDIAN/CARE PROVIDER _____

For more information, please contact:
Canadian Society for Exercise Physiology
www.csep.ca

KEY REFERENCES
1. Jamnik VJ, Warburton DER, Makarski J, McKenzie DC, Shephard RJ, Stone J, and Gledhill N. Enhancing the eectiveness of clearance for physical activity participation; background and overall process. APNM 36(S1):S3-S13, 2011.
2. Warburton DER, Gledhill N, Jamnik VK, Bredin SSD, McKenzie DC, Stone J, Charlesworth S, and Shephard RJ. Evidence-based risk assessment and recommendations for physical activity clearance; Consensus Document. APNM 36(S1):S266-s298, 2011.

The PAR-Q+ was created using the evidence-based AGREE process (1) by the PAR-Q+Collaboration chaired by Dr. Darren E. R. Warburton with Dr. Norman Gledhill, Dr. Veronica Jamnik, and Dr. Donald C. McKenzie (2). Production of this document has been made possible through financial contributions from the Public Health Agency of Canada and the BC Ministry of Health Services. The views expressed herein do not necessarily represent the views of the Public Health Agency of Canada or BC Ministry of Health Services.

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