Berkeley Rec Sports

Fitness Department
2301 Bancroft Way.
Berkeley, CA 94720
(510) 424-1432
RecSports.berkeley.edu

New Client Questionnaire

Name: _____ Date: _____

Address: _____ Age: _____

City: _____ State: _____ Zip: _____

Telephone: _____ Email: _____

To help us determine if you should check with your physician or other qualified healthcare provider before starting to exercise with a personal trainer, please read the following questions carefully and answer accordingly. All information will be kept confidential.

General Information - Please answer "**Y**" for Yes and "**N**" for No. Any "Yes" answer may require a check-in with your healthcare provider. You will receive an email follow-up prior to scheduling an appointment that will indicate if a medical clearance is needed.

GENERAL INFORMATION

A "Y" or "N" answer is required

Please read the questions below carefully and answer each one honestly: Check "Yes" for Yes and "No" for No		Yes	No
1.	Are you currently under the care of a physician or other healthcare provider for a medical or physical condition?	☐	☐
2.	Do you have any disability or medical condition of which our staff should be aware in order to meet your specific training needs (e.g., hearing or visual impairment, mobility limitations, diabetes, seizures, muscle spasticity)?	☐	☐
3.	Do you have a specific permanent or chronic medical or physical condition that may require you to take precautions when you exercise?	☐	☐
4.	Are you taking any medications that may affect your ability to safely exercise?	☐	☐
5.	Have you recently (in the last 3-6 months) had an injury that would impact your ability to exercise?	☐	☐
6.	Do you use a brace, assistive device, or prosthetic device for daily use and/or for sports or exercise?	☐	☐
7.	Have you ever had a heat or cold-related illness during exercise?	☐	☐
8.	Have you ever had autonomic dysreflexia, or abnormally high blood pressure associated with pounding headaches and other symptoms during exercise?	☐	☐
9.	Do you have any other concerns about your ability to safely engage in physical-exercise? If so, please describe	☐	☐

PAR-Q+

The Physical Activity Readiness Questionnaire for Everyone

The health benefits of regular physical activity are clear; more people should engage in physical activity every day of the week. Participiating in physical activity 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 physcially active.

SECTION 1 - GENERAL HEALTH

A "Y" or "N" answer is required

	Please read the 7 questions below carefully and answer each one honestly: Check “Yes” for Yes and “No” for 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)? *IF YES, PLEASE LIST CONDITION(S) HERE :* _____	☐	☐
5.	Are you currenlty taking prescribed medications for a chronic medical condition? *PLEASE LIST CONDITION(S) AND MEDICATIONS HERE:* _____	☐	☐
6.	Do you currently have (or have had within the past 12 months) a bone, joint, or soft tissue (muscle, ligament, or tendon) problem that could be made worse by becoming more physically active? *Please answer NO if you had a problem in the past, but it does not limit your current ability to be physically active.* *PLEASE LIST CONDITION(S) HERE:* _____	☐	☐
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 Global Physical Activity Guidelines for your age (https://www.who.int/publications/i/item/9789240015128)
- You may take part in a health and fitness appraisal.
- If you have any further questions, contact a qualified exercise professional such as Berkeley Rec Sports Certified Personal Trainer.
- If you are over the age of 45 yrs. and NOT accustomed to regular vigorous physical activity, please consult a qualified exercise professional 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 practicioner, 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 before continuing with any physical activity progamme.

SECTION 2 - GENERAL HEALTH

If you answered "Y" in section 1, a "Y" or "N" answer is required in this section

	Please read the questions below carefully and answer each one honestly: Check “Yes” for Yes and “No” for No	Yes	No
1.	Do you have Arthritis, Osteoporosis, or Back Problems? *If yes, answer questions 1a - 1c*	☐	☐
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*	☐	☐
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 radio therapy)?	☐	☐
3.	Do you have Heart Disease or Cardiovascular Disease? *If yes, answer questions 3a - 3e* This includes Coronary Artery Disease, High Blood Pressure, Heart Failure, Diagnosed Abnormality of Heart Rhythm	☐	☐
3a.	Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? *(Answer NO if you are not currenlty taking medications or other treatments)*	☐	☐
3b.	Do you have an irregular heart beat that requires medical management? (e.g. atrial fibrillation 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 Metabollic Conditions? *If yes, answer questions 4a - 4c* This includes Type 1 Diabetes, Type 2 Diabetes, Pre-Diabetes	☐	☐
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 metablic conditions (such as thyroid disorders, pregnancy-related diabetes, chronic kidney disease, liver problems)?	☐	☐
5.	Do you have any Mental Health Problems or Learning Difficulties? *If yes, answer questions 5a - 5b* This includes Alzheimer’s, Dementia, Depression, Anxiety Disorder, Eating Disorder, Psychotic Disorder, Intellectual Disability, Down Syndrome)	☐	☐
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?	☐	☐

SECTION 2 - GENERAL HEALTH

If you answered "Y" in section 1, a "Y" or "N" answer is required in this section

	Please read the questions below carefully and answer each one honestly: Check “Yes” for Yes and “No" for No	Yes	No
6.	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) *If yes, answer questions 6a - 6d*	☐	☐
6a.	Do you have difficulty controlling your condition with medication 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*	☐	☐
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-headed-ness, 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? *If yes, answer questions 8a - 8c* This includes Transient Ischemic Attack (TIA) or Cerebrovascular Event	☐	☐
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 - 9c*	☐	☐
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 Section 3 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 Berkeley Rec Sports Personal Trainer) 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 years and NOT accustomed to regular vigorous physcial activity, please consult a qualified exercise professional 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 and/or visit a or qualified exercise professional or further information.

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 practicioner, your physician, a qualified exercise professional, 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 physcial activity programme.

SECTION 3 - DECLARATION

- All persons who have completed the PAR-Q+ please read and sign the declaration below
- If you are less than the legal age required for consent or require the assent of a care provider, your parent, guardian or care must also sign this form

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 the community/fitness center may retain a copy of this form for records. In these instances, it will maintain the confidentiality of the same, complying with applicable law.

NAME _____ DATE _____

SIGNATURE _____ WITNESS _____

SIGNATURE OF PARENT/GUARDIAN/CARE PROVIDER _____

For more information, please contact
www.eparmedx.com
Email: eparmedx@gmail.com

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 the BC Ministry of Health Services

Citation for PAR-Q+
Warburton DER, Jamnik VK, Bredin SSD, and Gledhill N on behalf of the PAR-Q+ Collaboration. The Physical Activity Readiness Questionnaire for Everyone (PAR-Q+) and Electronic Physical Activity Readiness Medical Examination (ePARmed-X+). Health & Fitness Journal of Canada 4(2):3-23, 2011

Key References

1. Jamnik VK, Warburton DER, Makarski J, McKenzie DC, Shepard RJ, Stone J, and Gledhill N. Enhancing the effectiveness 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, McKensie DC, Stone J, Charlesworth S, and Shepard RJ. Evidence-based risk assessment and recommendations for physcial activity clearance; Consensus Document. APNM 36(S1):S266-s298, 2011.
3. Chrisholm DM, Collis ML. Kulak LL, Davenport W, and Gruber N. Physical activity readiness. British Columbia Medical Journal. 1975;17:375-378
4. Thomas S, Reading J, and Shepard RJ. Revision of the Physical Activity Readiness Questionnaire (PAR-Q). Canadian Journal of Sport Science 1992;17:4 338-345

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Medical Clearance Form

On the Physical Activity Readiness Questionnaire (PAR-Q) you just completed, you answered "Yes" to one or more questions in Section 1 and "Yes" to one or more follow up questions in Section 2 about your medical condition. For this reason, you need to have your healthcare practitioner complete and return this medical clearance form before you can begin working with a personal trainer. To expedite this process, we will gladly fax this form directly to your healthcare practitioner. We recognize that you are eager to start your fitness program, and we sincerely regret any inconvenience that this may cause you. However, please keep in mind that we want your exercise experience to be as safe as possible. All information will be kept confidential.

To your Healthcare Provider:

I hereby give my healthcare provider permission to review this form and release any pertinent medical information from any medical records to the staff at Berkeley Rec Sports.
Client Name (Print) _____
Client Signature_____Date_____ Healthcare Provider's name_____
Healthcare Providers Phone_____Fax_____

For Physician Use Only: Please check one of the following statements:

- ☐ I concur with my patient's participation with no restrictions.
- ☐ I concur with my patient's participation in the Personal Training program if they restricts activities to: _____
- ☐ I **do not** concur with my patient's participation in an exercise program (if checked, the individual will not be allowed to participate in the Rec Sports Personal Training Program).

_____ _____
Healthcare Provider's Signature Date

Return Form Instruction: Drop-Off: Rec Sports Fitness Department, 2301 Bancroft Way **Mail in:** Berkeley Rec Sports, Fitness Department, 2301 Bancroft Way, Berkeley, 94720 Attn: Robbie Earle, Personal Training Coordinator **Fax:** 9-1-510-664-4719 **Attn:** Robbie Earle, Personal Training Coordinator

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Participant's Name: _____
(Please Print)

UNIVERSITY OF CALIFORNIA, BERKELEY
Recreational Sports Department Facilities and Programs

Waiver of Liability, Assumptions of Risk, and Indemnity Agreement

UNIVERSITY OF CALIFORNIA, BERKELEY Recreational Sports Department Facilities and Programs Waiver of Liability, Assumptions of Risk, and Indemnity Agreement Waiver: In consideration of permission to use, today and all other future dates, the property, facilities, staff, equipment, services, and programs of the Recreational Sports Department, I, for myself, my heirs, personal representatives or assigns, do hereby release, waive, discharge, and covenant not to sue The Regents of the University of California, its directors, officers, employees, and agents from liability from any and all claims, including the negligence of the Recreational Sports Department Facilities and Programs resulting in personal injury, accidents or illnesses (including death), and property loss arising from, but not limited to, participation in activities, classes, observation, and use of facilities, premises, or equipment.

_____ _____

Signature of User Date Signature of Parent/Guardian Date

Assumption of Risks: Physical activity, by its very nature, carries inherent risks that cannot be eliminated regardless of the care taken to avoid injuries. The Recreational Sports Department has facilities for and provides for activities such as weight lifting, running, aerobic activities, classes, and sporting activities. Some of these involve speed and change of direction, and others involve sustained physical activity which places stress on the cardiovascular system. The specific risks vary from one activity to another, but the risks range from 1) minor injuries such as scratches, bruises, and sprains, 2) major injuries such as eye injury or loss of sight, joint or back injuries, heart attacks, and concussions, 3) catastrophic injuries including paralysis and death.

I have read the previous paragraphs and I know, understand, and appreciate these and other risks that are inherent in the activities made possible by the Recreational Sports Department Facilities and Programs. I hereby assert that my participation is voluntary and that I knowingly assume all such risks.

Indemnification and Hold Harmless: I also agree to INDEMNIFY AND HOLD the Regents of the University of California HARMLESS from any and all claims, actions, suits, procedures, cost expenses, damages, and liabilities, including attorney's fees brought as a result of my involvement at the Recreational Sports Department Facilities and Programs and to reimburse for any expenses incurred.

Severability: The undersigned further expressly agrees that the foregoing waiver and assumption of risk agreement is intended to be as broad and inclusive as is permitted by the law of the State of California and that if any portion thereof is held invalid, it is agreed that the balance shall, notwithstanding, continue in full legal force and effect.

Acknowledgment of Understanding: I have read this waiver of liability, assumption of risk, and indemnity agreement, fully understand its terms, **and understand that I am giving up substantial rights, including my right to sue.** I acknowledge that I am signing the agreement freely and voluntarily, and **intend by my signature to be a complete and unconditional release of all liability to the greatest extent by law.**

_____ _____

Signature of Client Date Signature Parent/Guardian Date

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Informed Consent - Personal Training

Client Name: _____ **Date:** _____

1. PURPOSE AND EXPLANATION OF PROGRAM: I hereby consent to voluntarily engage in personal training at Berkeley Rec Sports. I also give consent to receive information in a personal training program about activities which are recommended to me for improvement of dietary counseling, stress management, and health/fitness education activities. The levels of exercise I perform will be based upon my cardiorespiratory (heart and lungs) and muscular fitness. I understand that I may undergo an exercise assessment at the start of my personal training program to evaluate and determine my present level of fitness. I will be given exact personal instructions regarding the amount and kind of exercise I should do. A personal trainer will provide leadership to guide my activities, monitor my performance, and support goal achievement.

If I am taking prescribed medications, I have already so informed the program staff and further agree to so inform them promptly of any changes which my healthcare practitioner or I have made with regard to use of these. I understand that I will inform the program staff of any changes in my health status while participating in the personal training program. I will be given the opportunity for periodic fitness assessment at regular intervals after the start of the program. I have been informed that during my participation in the above described personal training program, I will be asked to complete the physical activities unless symptoms such as fatigue, shortness of breath, chest discomfort or similar occurrences appear.

I understand that it is my complete right to decrease or stop exercise and that it is my obligation to inform the personal training program personnel of my symptoms, should any develop. I understand that during the performance of exercise, a personal trainer will monitor my performance or assess my feelings of effort for the purposes of monitoring my progress. I also understand that the personal fitness trainer may reduce or stop my exercise program when any of these findings so indicate that this should be done for my safety and benefit. I also understand that during the performance of my personal training program physical touching and positioning of my body may be necessary to assess my muscular and bodily reactions to specific exercises, as well as to ensure that I am using proper technique and body alignment. I understand that I have the right to inform my personal trainer if I do not consent to the physical contact for the stated reasons above.

I understand that Rec Sports wants to ensure that I have a positive, supportive, and collaborative relationship with the personal trainer. If for any reason, these expectations are not met, I understand that I can request an assignment to a different trainer for any reason at any time. I also understand that Rec Sports personal trainers do not provide medical diagnosis or treatment, physical rehabilitation services, or massage therapy.

2. RISKS: I understand that there exists the remote possibility during exercise of adverse changes including, but not limited to, abnormal blood pressure, fainting, dizziness, disorders of heart rhythm, and in very rare instances of heart attack, stroke, or even death. I further understand and I have been informed that there exists the risk of bodily injury including, but not limited to, injuries to the muscles, ligaments, tendons, and joints of the body. Every effort will be made to minimize these occurrences by proper staff assessments of my condition before each personal fitness training session, staff supervision during exercise and by my own careful control of exercise efforts. I fully understand the risks associated with exercise, including the risk of bodily injury, heart attack, stroke or even death, but knowing these risks, it is my desire to participate in the personal training program.

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3. BENEFITS TO BE EXPECTED AND ALTERNATIVES AVAILABLE TO EXERCISE: I understand that this program may or may not benefit my physical fitness or general health. I recognize that involvement in the personal training sessions will allow me to learn proper ways to perform conditioning exercises, use fitness equipment, and regulate physical effort. These experiences should benefit me by indicating how my physical limitations may affect my ability to perform various physical activities. I further understand that if I closely follow the program instructions, that I will likely improve my exercise capacity and fitness level after a period of 3-6 months.

4. CONFIDENTIALITY AND USE OF INFORMATION The information which is obtained in this personal training program will be treated as privileged and confidential and will not be released without prior consent. I understand that information which is not personally identifiable with me will be used for program statistical purposes only so long as the same does not identify my person or provide facts which could lead to my identification. Information obtained will be used internally by the program staff to evaluate my exercise status or needs.

5. INQUIRIES AND FREEDOM OF CONSENT I have been given an opportunity to ask questions as to the personal training program. I have read this Informed Consent form, fully understand its terms, and sign it freely and voluntarily without inducement.

_____

Client Name (Print)

_____

Client Signature Date

_____

Witness Signature Date

Return Waiver of Liability and Informed Consent Forms:

Drop-Off: Rec Sports Fitness Department, 2301 Bancroft Way., Berkeley, CA 94720

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Attn: Robbie Earle, Personal Training Coordinator

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