



Medical History

Name (Please Print) _____ Phone # _____

Date of Birth ___/___/___ Height _____ Weight _____ Gender _____

Emergency Contact (Please Print): _____ Phone # _____

Do you have a history of the following?

YES | NO

- Heart attack
- Heart surgery
- Cardiac catheterization
- Coronary angioplasty (PTCA)
- Pacemaker / implantable cardiac defibrillator / rhythm disturbance
- Heart valve disease
- Heart failure
- Heart transplant
- Congenital heart disease

Do you have any of the following symptoms?

YES | NO

- You experience chest discomfort with exertion
- You experience *unreasonable* breathlessness
- You experience dizziness, fainting, blackouts. If so explain _____
- You take heart medications

Please mark ALL true statements

- You are a male older than 45 years
- You are a woman older than 55 years or you have had a hysterectomy or you are post-menopausal
- You smoke or have quit smoking within the previous 6 months
- Your blood pressure is greater than 140 / 90 or you take blood pressure medication
- Your blood cholesterol is greater than 200 mg /dL
- You have a close blood relative who had a heart attack before age 55 (father or brother) or age 65 (mother or sister)
- You are 20lbs. over your normal weight
- You are physically inactive (i.e. you get less than 30 minutes of physical activity on at least 3 days/week)
- You are diabetic
- You have been diagnosed with kidney disease
- You have been diagnosed with thyroid or other endocrinological disorder
- You have respiratory problems, such as asthma, chronic bronchitis, emphysema or COPD
- You have muscular problems, arthritis, orthopedic problems or have had a previous injury that may limit your physical activity
- You are pregnant
- You experience a cramping sensation in your lower legs when walking short distances



List all surgeries you've had in the past year. Also list any current joint or muscle issues.

List all medications you take on a regular basis:

Medication	Reasons
<hr/>	<hr/>

(If you refuse to list medications we require the medical waiver signed by a physician)

I understand that I may be undergoing physical exertion while participating in services and activities at or associated with the Boston University Fitness and Recreation Center and I certify that my level of physical fitness is sufficient for the activities in which I choose to take part. In acknowledging that I am aware of and willing to assume the risks associated with these activities and services, I hereby voluntarily agree to waive, hold harmless and indemnify the Trustees of Boston University and its agents, volunteers and employees from any and all claims demands, damages and causes of action of any nature whatsoever arising out of ordinary negligence which I, my heirs, my assigns or successors may have against them for, on account of, or by reason of my voluntary participation in services and activities at or associated with the Boston University Fitness and Recreation Center. I understand the content of this document, and I execute this INFORMED CONSENT AND WAIVER OF CLAIM FORM of my own free will and accord.

Name of Participant (Print): _____

Signature of Participant: _____ Date: _____

Signature of Parent or Guardian (If under 18 years of age): _____

YES / NO I have read and understood the questions asked. I verify that all the information noted above is accurate to the best of my knowledge.

Signature: _____ Date: _____



Medical Waiver

Male participants over 45 years of age and female participants over 55 years of age are required to submit a **Medical Waiver** signed by their physician before participating in a recreational program.

Those with coronary risk factors such as smoking, high blood pressure, high cholesterol, diabetes or a history of heart disease are required to submit the **Medical Waiver** signed by their physician regardless of their age.

Note to Physician:

_____ is entering a Personal Training program being offered by the Boston University Department of Physical Education, Recreation, and Dance. Your signature indicates that your patient is medically qualified to participate in our program. Without your consent he/she cannot participate.

Description of the program:

Frequency: _____ Intensity: _____

Duration: _____ Mode: _____

Physician's recommended limitations to heart rate, weight lifted or movement patterns:

Physician's signature

Date

Physician's name (please print) _____

Office phone (_____) _____ - _____

Please bring to the Fitness Department, fax to (617) 353-5147, or scan and email to fitness@bu.edu.

The Medical Waiver is valid for one year from the date that it is signed by the physician. The above procedures are recommended by the American College of Sports Medicine.



PERSONAL TRAINING POLICIES

SCHEDULING:

To schedule your **initial session**:

1. Complete Interest Form, Health History Questionnaire, and Policies forms and either return, email, or fax them to the Fitness Department at (617) 353-5147.
2. Register and pay for package online at <http://www.bu.edu/fitrec/fitness/personal-training/> or in person within the **PERD Office** at FitRec Monday through Friday 9:00am – 5:00pm.
3. Schedule your initial training session by e-mailing fitness@bu.edu.

All **future sessions**; rescheduling or cancellation of personal training services should be done through your trainer. Contact the Fitness Department at fitness@bu.edu or 617-358-3760 if you have concerns or questions. All training session dates and times will be scheduled before the first session of the package commences.

CANCELLATION/RESCHEDULING POLICY

If you need to cancel or reschedule a session, please contact your trainer. 24 hours-notice is required for a cancellation or rescheduling in order to receive credit for the session. Failure to cancel within this time frame or failure to show up for a session will result in the client being charged for the session. Exceptions will only be made in the case of a medical emergency accompanied by a doctor’s note. There is a no-refund policy on all packages purchased – a client may only receive a refund if accompanied by a doctor’s note.

TARDINESS POLICY:

Clients are expected to begin working out at the start time of the scheduled appointment. A late start time does not entitle a client to a session longer than the scheduled appointment.

PERSONAL TRAINING PACKAGES DO NOT EXPIRE

I verify that I understand and will abide by these policies

Client Signature _____ **Date** _____



PERSONAL TRAINING INTEREST FORM

Name: _____ Date: _____

Cell Phone: _____ Office Phone: _____ E-Mail: _____

BU Affiliation: STUDENT ALUMNI FACULTY/STAFF FRIENDS OF BU

Sex: Male Female Age: _____

Trainer preference (if any): _____

Check off the type of service are you interested in:

Individual Personal Training

Semi-private Training

Body Fat Testing

Fitness Evaluation

Program Design

Combo Pack (Fitness Evaluation + Program Design)

How many sessions are you interested in? 1 session 5 sessions 10 sessions

How many sessions per week? _____

Availability: Please list the times you are available on each day. Circle the top 2 times you would prefer if they are available.

Monday: _____

FitRec Hours: 6am-11pm

Tuesday: _____

FitRec Hours: 6am-11pm

Wednesday: _____

FitRec Hours: 6am-11pm

Thursday: _____

FitRec Hours: 6am-11pm

Friday: _____

FitRec Hours: 6am-10pm

Saturday: _____

FitRec Hours: 8am-10pm

Sunday: _____

FitRec Hours: 8am-10pm

Fitness Goals- (Be as specific as possible)



EXERCISE EFFECTIVELY WITHOUT INJURY, STREAM- LINE YOUR BODY, AND RELAX TENSE, SORE MUSCLES ALL WHILE HAVING FUN!

PILATES-BASED CONDITIONING

Large group exercise class based on the floor with a focus on strength and coordination

PILATES APPARATUS

Small group training (max 4 students per class) using the Pilates reformer and small equipment to target lower abs, upper back, gluteal muscles and hamstrings

PRIVATE PILATES TRAINING

Gain individual knowledge of your postural habits and areas in need of improvement. Learn faster and get the most customized program possible

FREE 30 MINUTE PILATES INTRODUCTORY SESSION

Fridays, 12 - 2pm in FitRec L249

Learn about classes, discuss your goals, tour the equipment and get recommendations

**To schedule an appointment, call Ann Allen at
617-353-4041 or email aballen@bu.edu**

To register for classes visit bu.edu/fitrec/pilates
