

**Fitness Training Services Application**

Thank you for your interest in one of our fitness training services with Boston College Campus Recreation. We are committed to helping Boston College students, faculty, staff and affiliates reach their fitness goals through a variety of services and programs. For a description of these services, please see our website, [www.bc.edu/rec](http://www.bc.edu/rec).

All members interested in signing up for a service must read and complete the Fitness Training Services Application, which includes the application, policies, and health history questionnaire. Please fill out the forms with as much detail as possible.

The forms must be hand delivered in a sealed envelope with a signature across the seal to Member Services. In an effort to protect your privacy and medical information, we will not accept e-mailed, mailed or faxed forms. Upon review of the forms you turn in it may be required for you to provide a medical waiver. You will be notified by the Fitness Professional Staff if the medical waiver is necessary. Payment is required prior to receiving the service.

Only members of Boston College Campus Recreation are eligible to sign up for a fitness training service. Please keep in mind, we cannot guarantee placement with a specific personal trainer due to demand. If signing up for personal training, the client is assigned based on preferences, goals and trainer availability.

A final note on nutrition: Nutrition is an ever-evolving science. And, food is at the center. Food is a source of fuel, and enjoyment; it is not a source of stress or anxiety. In alignment with the Office of Health Promotion and iNourish, BC Rec personal trainers and group fitness instructors coach on food as nourishment, while honoring our clients’ relationships with food. All fitness staff are prohibited from providing meal plans and recommending supplements, as these topics are outside the scope of practice. Referrals for nutrition services will be made available when possible.

If you have any additional questions, please contact us. Congratulations and good luck as you work toward your personal health and fitness goals!

Yours in Health,

The Fitness Staff

[fitness.center@bc.edu](mailto:fitness.center@bc.edu)



*Staff Use Only*

Date Received: **\_\_\_\_/\_\_\_\_/\_\_\_\_**

**Fitness Training Services Application**

**Please check the fitness training service you are applying for:**

□ Health and Fitness Assessment: Resting measurements to assess health including body composition, and physical tests to

gauge submaximal cardiovascular fitness, muscular endurance, neuromuscular balance, and flexibility.

□ InBody Assessment: Resting measurements to assess body composition. *Not available if you have an implanted defibrillator or pacemaker, are pregnant, or during menstruation.*

□ Personal Training: Personal training sessions based on the individual’s workout history, goals, and physical limitations.

□ Small Group Training: Group sessions following a certain format, not individualized.

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Eagle ID #:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Status (*check one*): □ Student □ Faculty/Staff □ Alumni □ Other**

**Email Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Preferred Method of Communication: □ Phone □ Email □ Other**

1. **In the past 3 months how often have you engaged in physical activity (i.e., exercise)?**

**□ 3-4 times/week □ 1-2 times/week □ 1-2 times/month □ not at all in the past 3 months**

1. **What are your personal barriers to exercise (i.e., reasons you do not exercise)?**
2. **What types of exercise do you prefer?**
3. **Are you interested in working on any fitness goals? If yes, then please list your goal(s) below?**
4. **Please list any current or past injuries/health concerns that may affect your physical performance.**



**Personal Training Preferences**

***Please indicate your preferences if you are interested in working with a personal trainer. You do not need to fill out this section if seeking an assessment or participation in a small group class.***

**Prefered # of personal training sessions per week:** \_\_\_\_\_\_\_\_\_\_**x/week**

**Individual or partner training:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(if partner, then also write their name)

**Please indicate a time frame that you are available in the appropriate box. (ex. Afternoon: M, W 12-2pm)**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Monday** | **Tuesday** | **Wednesday** | **Thursday** | **Friday** | **Saturday** | **Sunday** |
| **AM** |  |  |  |  |  |  |  |
| **PM** |  |  |  |  |  |  |  |

1. **Is there a personal trainer you would prefer working with or a type of trainer you would prefer working with? If you know the trainer you would like to work with, then please write their name.**
2. **Please share any additional information that might be helpful in selecting a personal fitness trainer to meet your needs.**

1. **What type of information would you like your personal trainer to cover in your sessions with him/her?**

***For Professional Staff Use Only***

**Notes:**



**Fitness Training Services Policies**

***Below we have listed a few policies about our Fitness Training Services. Please read the following and initial to acknowledge agreement.***

**Payment**

\_\_\_\_\_\_\_Payment for services is due to Member Services prior to participation in any Fitness Training Service.

**Scheduling/Cancellations**

\_\_\_\_\_\_\_The scheduling of assessments and personal training sessions is done through the client and personal trainer.

\_\_\_\_\_\_\_The scheduling of small group classes cannot be altered. In the event of a cancellation on behalf of Boston College Campus Recreation, an effort will be made to reschedule the class as soon as possible.

\_\_\_\_\_\_\_Individual Cancellation Policy: If you need to cancel or reschedule a session, please contact your trainer. Cancellations and rescheduling require 24-hours’ notice. 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.

\_\_\_\_\_\_\_Partner Cancellation Policy: The partner training policy is the same as the individual training policy since discounted packages are not available for partner training. If one partner cancels a training session and the other partner would like to participate, then the session can still be offered to the one client. Failure to cancel within 24 hours or failure to show up for a session will result in the client(s) being charged for the session.

\_\_\_\_\_\_\_Small Group Cancellation Policy: The scheduling of small group classes cannot be altered by the participant (cancelled or rescheduled). As a courtesy, please notify your trainer if you will be unable to attend class.

**Tardiness**

\_\_\_\_\_\_ Personal training clients are expected to begin their session 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. Unless notified in advance, trainers will wait 15 minutes at the start of the scheduled session, and then the client will be charged for the session.

\_\_\_\_\_\_\_Small group training participants please be on time to ensure participation in the group warm-up which is important for your safety. If you are going to be late, then please notify your trainer in advance.

\_\_\_\_\_\_\_If the trainer is tardy the client has the right to either ask the trainer if he/she can complete the full session as planned, or to reschedule the session.

**Health Status**

\_\_\_\_\_\_\_As a participant in Fitness Training Services it is important that you notify your trainer of any prescription changes or medical conditions should they occur during your time working with a trainer.

**Expiration Dates & Refunds**

\_\_\_\_\_\_\_All assessments and personal training sessions expire after 6 months from the date of purchase. Sessions are non-refundable unless due to a medical reason with a doctor’s note.

\_\_\_\_\_\_\_Registration for small group training is non-refundable unless due to a medical reason with a doctor’s note.

**I verify that I understand and will abide by these policies.**

**Client Signature** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# bc rec logo.png

# Health History Questionnaire

# Name (Please Print) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_ Height \_\_\_\_\_\_\_\_\_\_\_ Weight \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender M F

**Section 1 – General Health**

*Please check all medical problems you have experienced within one year (unless indicated otherwise). If you marked any of these statements in this section, consult your physician or other appropriate health care provider before engaging in exercise. You may need to use a facility with a medically qualified staff.*

# Check if you have any of the following health issues:

**□**You have diabetes

**□**You have asthma or other lung disease

**□**You have burning or cramping sensation in your lower legs when walking short distances

**□**You have musculoskeletal problems that limit your physical activity

**□**You have concerns about the safety of exercise

**□**You are pregnant

**Check if you have a history of the following:**

**□**Heart attack

**□**Heart surgery

**□**Cardiac catheterization

**□**Coronary angioplasty (PTCA)

**□**Pacemaker / implantable cardiac defibrillator / rhythm disturbance

**□** Heart valve disease

**□**Heart failure

**□**Heart transplantation

**□**Congenital heart disease

# Check if you experience the following symptoms:

**□**You experience chest discomfort with exertion

**□**You experience unreasonable breathlessness

**□**You experience dizziness, fainting or blackouts

**□**You take heart medications

**□ If you checked *any* of the statements in this section**, please have your doctor complete the medical release prior to submitting your application.

Check_mark_23x20_02

**□ If you checked *2 or more* of the statements in this section**, please have your doctor complete the medical release prior to submitting your application.

**Section 2 – Cardiovascular Risk Factors**

## Check_mark_23x20_02

**□ If you checked *2 or more* of the statements in this section**, please have your doctor complete the medical release prior to submitting your application.

**□**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 postmenopausal

**□**You smoke, or quit smoking within the previous 6 months

**□**Your blood pressure is greater than 140 / 90 mm Hg

**□**You take blood pressure medication

**□**Your blood cholesterol is greater than 200 mg/dL or HDL < 35 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 physically inactive (you get less than 30 minutes of physical activity on at least 3 days/week)

**□**You are greater than 20 pounds overweight (could remove, but still listed as CVD risk factor everywhere – may need to keep for liability reasons.)

**Section 3 – SCOFF questionnaire plus 2 additional questions**

#### Check_mark_23x20_02

**□ If you checked *2 or more* of the statements in this section**, please have your doctor complete the medical release prior to submitting your application.

**□**Do you make yourself sick because you feel uncomfortably full?

**□**Do you worry you have lost control over how much you eat?

**□**Have you recently lost more than 13 lbs in a three-month period?

**□**Do you believe yourself to be fat when others say you are thin?

**□**Would you say food dominates your life?

**□**Are you satisfied with your eating patterns?

**□**Do you ever eat in secret?

#### Please list all medications you take on a regular basis:

**Medication Reason**

**­­­1.** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**3.** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please sign below if in agreement:**

I have read and understood the questions asked. I verify that all the information noted above is accurate to the best of my knowledge.

**Client Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emergency Contact Name, Relationship, and Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**



**Medical Release**

Dear Primary Care Provider:

Your patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ is participating in Boston College Campus Recreation’s personal training program. Your signature as his or her healthcare provider indicates that your patient is medically cleared to participate in fitness training provided by Boston College Campus Recreation. Without your consent your patient will not be able to participate. Boston College Campus Recreation is not a medically supervised facility and does not provide rehabilitative services as they are beyond our scope of practice.

**Report of Primary Care Provider**

**□** I know of no reason why the applicant may not participate

**□** I believe the client can participate, but I urge caution because:

**□** The client should not engage in the following activities:

**□** I recommend that the client NOT participate

Please include any other recommendations or restrictions on a separate page.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Health Care Provider’s Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Health Care Provider (MD, DO, PA-C, or NP) Office Phone

*To protect your privacy: Please do not fax, mail or email this form. This form must be hand delivered to Member Services in a sealed envelope with your signature across the seal.*

