



# Client Information

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Name: \_\_\_\_\_ Member #: \_\_\_\_\_

Address: \_\_\_\_\_

Phone (home): \_\_\_\_\_ Other: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

When was your last physical exam? \_\_\_\_\_

Please list any medications you are taking and why. (use back if necessary)

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Have you been diagnosed with arthritis? \_\_\_\_\_

Have you ever had back problems?

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Have you ever had any other bone, joint or muscular problems? (use back if necessary)

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FEMALES ONLY. Are you pregnant or do you have any reason to believe you may be pregnant?

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# Preparticipation Health Screening

Name: \_\_\_\_\_ Sex: \_\_\_\_\_ Age: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Blood Pressure: \_\_\_\_\_

## Coronary Artery Disease Risk Factor Thresholds

### Positive Risk Factors

**Y N** Family History:

- Father, brother or son had heart attack, surgery for artery blockage, or sudden death before age 55. **OR**
- Mother, sister or daughter had heart attack, surgery for artery blockage, or sudden death before age 45.

**Y N** Cigarette Smoking

- Current smoker or quit in past 6 months

**Y N** Hypertension

- Systolic blood pressure higher than 140 mmHg **OR**
- Diastolic blood pressure higher than 90 mmHg **OR**
- Currently on medication to control hypertension

**Y N** High Cholesterol

- Low density lipoprotein (LDL) cholesterol greater than 130 mg/dl **OR**
- High density lipoprotein (HDL) cholesterol lower than 35 mg/dl **OR**
- Total cholesterol greater than 200 mg/dl **OR**
- Currently taking lipid lowering medications

**Y N** Impaired Fasting Glucose

- Fasting glucose greater than 110 mg/dl

**Y N** Obesity

- Body fat greater than: 29% (male) 32% (female) **OR**
- BMI greater than or equal to 30 kg/m<sup>2</sup> **OR**
  - BMI = weight (kg)/height (m)<sup>2</sup>
- Waist girth greater than 100 cm measured at naval

**Y N** Sedentary Lifestyle

- Accumulates **LESS THAN** 30 minutes of moderate physical activity on most days of the week

### Negative Risk Factor

**Y N** High serum HDL cholesterol

- Greater than 60 mg/dl

## Major Signs and Symptoms Suggestive of Cardiovascular and Pulmonary Disease

- Y N Pain or discomfort in the chest, neck, jaw, arms or other areas that may be due to lack of blood flow
- Y N Shortness of breath at rest or with mild exertion
- Y N Dizziness or fainting spells
- Y N Ankle/ foot edema not related to an injury that is increased with exercise
- Y N Palpitations or fast heart rate
- Y N Known heart murmur
- Y N Unusual fatigue or shortness of breath with usual activities

## Risk Stratification

### High Risk

- All individuals with hypertension, high cholesterol and impaired fasting glucose
- All individuals with one or more signs and symptoms
- Individuals with known:
  - Cardiac, peripheral vascular or cerebrovascular disease
  - Chronic obstructive pulmonary disease, asthma, interstitial lung disease or cystic fibrosis
  - Diabetes mellitus, thyroid disorders, renal or liver disease

### Moderate Risk

- All individuals with two or more risk factors not including hypertension, high cholesterol and impaired fasting glucose

### Low Risk

- Men younger than 45 and women younger than 55 who have no more than one risk factor and no major signs and symptoms

## Recommendations for Exercise and Exercise Testing

**Moderate Exercise or Submaximal Exercise Test:** exercise that can be maintained by the individual for more than 45 minutes or exercising at 55-65% of max heart rate.

- Low and Moderate Risk: physician clearance not necessary
- High Risk: physician clearance recommended

**Vigorous Exercise:** jogging at 5 mph or more or exercising at 75% of max heart rate or higher

- Low Risk: physician clearance not necessary
- Moderate and High Risk: physician clearance recommended

Trainer: \_\_\_\_\_  
Phone: 952.496.6881  
Fax: 952.445.6117

Physician: \_\_\_\_\_  
Hospital: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Fax: \_\_\_\_\_

# Dakotah!

SPORT AND FITNESS

2100 Trail of Dreams • Prior Lake Minnesota 55372

## Medical Clearance Form

Date: \_\_\_\_\_

Dear Dr. \_\_\_\_\_

Your Patient, \_\_\_\_\_, wishes to participate in an exercise program at Dakotah Sport and Fitness. If your patient is taking medication that will affect his or her heart rate response to exercise, please indicate the manner of the effect (raises, lowers, or has no effect on heart rate response or other effects):

Type of medication and effect: \_\_\_\_\_

Report of Physician:

\_\_\_\_\_ I know of no reason why the applicant may not participate in exercise.

\_\_\_\_\_ I believe the applicant can participate but I urge caution because:

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

\_\_\_\_\_ The applicant should not engage in the following activities: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_ I recommend that the applicant NOT participate.

Physician signature \_\_\_\_\_ Date \_\_\_\_\_

Thank You,



## Cancellation Policy

Personal training is a time commitment for members as well as trainers. Therefore, Dakotah! Sport and Fitness utilizes a cancellation policy for all personal training sessions.

**To cancel a training session you must:**

**Notify your trainer 24 hours in advance by calling:**

952-496-6874 and leave a message

or

\_\_\_\_\_

**If you fail to give a 24-hour notice you will be charged your FULL SESSION RATE.**

Exceptions to this policy include illness and family emergency.

I have read the above cancellation policy and understand the policy.

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Trainer Signature

\_\_\_\_\_  
Date