Galter LifeCenter
The science of feeling better

5157 N. Francisco Ave.
Chicago, IL 60625
773-878-9936
GalterLifeCenter.org

Welcome to Personal Training at Galter LifeCenter!

Together, you and your trainer will develop a balanced exercise program to address your specific needs, goals and lifestyle.

Your experience will include:

Evaluation

- Review of health history questionnaires
- Fitness Assessment
  - Cardiovascular Endurance
  - Muscular Strength
  - Muscular Endurance
  - Flexibility
  - Body Composition
  - Balance, Posture, Alignment
- Intake of recommendations from health care providers (Physician, Nurse Practitioner, Physical Therapist, Dietitian, Massage Therapist, Chiropractor, etc.)

These baseline measurements will be gathered during your first session.

- Goal-Setting
  - After assessing your health and fitness status, your trainer will guide you in setting clear, measurable and realistic goals.

Program Design

- Based on your evaluation results and goals, the trainer will create a comprehensive program to address your goals. Get ready for a smart workout, support, motivation and FUN!

Re-evaluation

- Your trainer will periodically repeat the fitness assessments in order to measure change and monitor progress toward your goals.

Please read and complete the attached forms and bring them to your first appointment. Come dressed for exercise, as your fitness evaluation will take place during that session. Feel free to contact Amy Beck, Personal Training Manager, 773-878-9936, ext. 7318 or ABeck@SwedishCovenant.org, at any time with questions or comments. Experience the Science of Feeling Better at Chicago's Leading Medical Fitness Center!

Personal Training Guidelines

1. All clients must complete the proper paperwork, including guidelines, health history, exercise history and liability waiver prior to beginning a personal training program. For your safety a physician's release for exercise may be necessary before participation is approved.

2. All personal training sessions must be purchased in advance.

3. The client is responsible for checking in at the Courtesy Desk prior to each session to redeem ("burn") a session from the prepaid package. Please allow time to do this before the scheduled appointment.

4. 24 hours' notice is required to change or cancel personal training appointments. If 24 hours' notice is not given, the session will be forfeited. Please notify your trainer directly in the case that you need to change or cancel an appointment.

5. If a personal trainer cancels an appointment with less than 24 hours notice, the trainer will provide one session at no charge.

6. All personal training sessions will expire six months from the date of purchase. Extensions must be approved by the manager.

7. In the case of a trainer's illness or vacation, the client may request a substitute trainer.

8. Our goal is to provide you with excellent service! Please contact us any time; we welcome any questions and feedback.

Please sign below to indicate that you have read and understood these guidelines.

Thank you!

Amy Beck
Personal Training Manager
773-878-9936, ext. 7318
ABeck@SwedishCovenant.org

CLIENT'S SIGNATURE DATE (MM/DD/YY)

Health History and Physical Activity Readiness Questionnaire

Client Information

NAME		SEX ❑ M ❑ F	BIRTHDATE (MM/DD/YY) / /
ADDRESS	CITY	STATE	ZIP
HOME PHONE	WORK OR CELL PHONE	EMAIL ADDRESS	
PHYSICIAN NAME		OFFICE PHONE	
PHYSICIAN ADDRESS	CITY	STATE	ZIP
EMERGENCY CONTACT	RELATIONSHIP	PHONE	

Exercise Survey

OCCUPATION	WORK DAY ACTIVITY LEVEL ❑ Sedentary ❑ Active
Current exercise program ❑ Yes ❑ No	Describe
Frequent sports activities ❑ Yes ❑ No	Describe
Do you take your pulse during exercise ❑ Yes ❑ No	How high does it go up?
What is your main reason for joining Galter LifeCenter?	
What are your main exercise goals?	

Goals

Please circle the exercise goals that are important to you

Improve cardiovascular fitness	Improve moods and stress	Feel Better
Body-fat or weight loss	Improve flexibility	Enjoyment
Reshape or tone my body	Increase strength	Other
Improve sport performance	Increase energy level	_____

General Heath Condition

Does your physician know you are participating in this exercise program?	❑ Yes ❑ No
Do you have any pre-existing physical or medical condition that could be aggravated by exercise?	❑ Yes ❑ No
Obesity (more than 20% over ideal weight)	❑ Yes ❑ No

List your current medications (prescription and over-the-counter):

_____

_____

_____

_____

_____

_____

Lifestyle and Health History Questionnaire

This questionnaire serves as a part of a pre-screening tool for both exercise testing and exercise participation. If you respond yes to any of the questions, medical clearance may be necessary before participating in exercise testing or an exercise program is allowed.

Health History

1. How would you describe your present state of health?
   ❑ very well ❑ healthy ❑ unhealthy ❑ ill ❑ other:_____
2. When was the last time you visited your physician? _____
3. Have you ever had your cholesterol checked? ❑ Yes ❑ No
   Date of test:_____ What were the results?
   Total Cholesterol:_____ HDL:_____ LDL:_____ TG:_____
4. Have you ever had your blood sugar checked? ❑ Yes ❑ No What were the results?_____

Please check the appropriate boxes below and explain any items marked YES.

5. Past History		If yes, please explain
Allergies	❑ Yes ❑ No	
Amenorrhea	❑ Yes ❑ No	
Anxiety	❑ Yes ❑ No	
Arthritis	❑ Yes ❑ No	
Asthma	❑ Yes ❑ No	
Celiac disease	❑ Yes ❑ No	
Chronic sinus condition	❑ Yes ❑ No	
Constipation	❑ Yes ❑ No	
Crohn's disease	❑ Yes ❑ No	
Depression	❑ Yes ❑ No	
Diabetes	❑ Yes ❑ No	
Diarrhea	❑ Yes ❑ No	
Disease of the arteries, stroke	❑ Yes ❑ No	
Eating disorder	❑ Yes ❑ No	
Epilepsy mellitus	❑ Yes ❑ No	
Gastroesophageal reflux disease (GERD)	❑ Yes ❑ No	
Heart attack	❑ Yes ❑ No	
Heart murmur	❑ Yes ❑ No	
High blood pressure	❑ Yes ❑ No	
Hypoglycemia	❑ Yes ❑ No	
Hypo/hyperthyroidism	❑ Yes ❑ No	
Insomnia	❑ Yes ❑ No	
Intestinal problems	❑ Yes ❑ No	
Irritability	❑ Yes ❑ No	
Irritable bowel syndrome (IBS)	❑ Yes ❑ No	

5. Past History (continued)		If yes, please explain
Lung disease / problems	❑ Yes ❑ No	
Major surgeries	❑ Yes ❑ No	
Menopausal symptoms	❑ Yes ❑ No	
Pregnant	❑ Yes ❑ No	
Premenstrual syndrome (PMS)	❑ Yes ❑ No	
Polycystic ovary syndrome (POSC)	❑ Yes ❑ No	
Osteoporosis	❑ Yes ❑ No	
Skin problems	❑ Yes ❑ No	
Ulcer	❑ Yes ❑ No	
Past injuries (back, knees, ankles, other)	❑ Yes ❑ No	
Describe any other health conditions that you may have had		
6. Family History (immediate family)		
Cancer	❑ Yes ❑ No	
Congenital heart disease	❑ Yes ❑ No	
Diabetes	❑ Yes ❑ No	
Heart attacks	❑ Yes ❑ No	
Heart operations	❑ Yes ❑ No	
High blood pressure	❑ Yes ❑ No	
High cholesterol	❑ Yes ❑ No	
Osteoporosis	❑ Yes ❑ No	
Other major illness	❑ Yes ❑ No	
7. Present Symptoms		
Arthritis	❑ Yes ❑ No	
Awake short of breath	❑ Yes ❑ No	
Back pain	❑ Yes ❑ No	
Chest pain	❑ Yes ❑ No	
Cough or exertion	❑ Yes ❑ No	
Coughing up blood	❑ Yes ❑ No	
Heart palpitations	❑ Yes ❑ No	
Shortness of breath	❑ Yes ❑ No	
Swollen legs	❑ Yes ❑ No	
Use more than one pillow for sleep	❑ Yes ❑ No	
Other	❑ Yes ❑ No	

Diet and Eating Habits

8. What are your dietary goals? _____

9. Have you ever followed a modified diet? ❑ Yes ❑ No

   If so, describe: _____

10. Are you currently following a specialized diet (e.g., low-sodium or low fat)? ❑ Yes ❑ No

    If so, describe: _____

11. Why did you choose this diet? _____

    Was the diet prescribed by a physician? ❑ Yes ❑ No

    How long have you been on the diet? _____

12. Have you ever met with a registered dietitian? ❑ Yes ❑ No

    Are you interested in meeting with one? ❑ Yes ❑ No

13. What do you consider to be the major issues in your diet and eating plan? (e.g., eating late at night, snacking on high-fat foods, skipping meals or lack of variety) _____

14. How many 8-ounce glasses of water do you drink per day? _____

15. Do you have any food allergies or intolerance? ❑ Yes ❑ No Describe: _____

16. Who prepares your food? ❑ Self ❑ Spouse ❑ Parent ❑ Minimal preparation

17. How many times per week do you dine out? _____

18. Please specify the type of restaurants you dine at for each meal:

    Breakfast: _____ Lunch: _____

    Dinner: _____ Snacks: _____

19. Do you crave any foods? ❑ Yes ❑ No Specify: _____

20. How is your appetite affected by stress? ❑ Increased ❑ Not affected ❑ Decreased

21. Do you drink alcohol? ❑ Yes ❑ No How many drinks per week? _____

22. Do you drink caffeinated beverages? ❑ Yes ❑ No Average number per day: _____

23. Do you use tobacco? ❑ Yes ❑ No How much (cigarettes, cigars, chewing tobacco) per day?_____

24 Do you take any vitamin, mineral or herbal supplements? ❑ Yes ❑ No

    Please list type and amount per day: _____

Sports and Physical Activity

25. Do you currently participate in any structured physical activity? ❑ Yes ❑ No

    If so, please describe: ____ minutes of cardiovascular activity, ____ times per week

    ____ strength-training sessions per week

    ____ minutes of flexibility training, ____ times per week

    ____ minutes of sports per week

    List sports: _____

    Do you engage in any form of regular physical activity: ❑ Yes ❑ No Describe: _____

    Please describe your activity level during the work day: _____

26. Have you experienced any injuries that may limit your physical activity?

    If so, please describe: _____

27. On a scale of 1–10, how ready are you to adopt a healthier lifestyle: 1 = very unlikely to 10 = very likely _____

Weight History

28. What would you like to do with your weight? ❑ Lose weight ❑ Gain weight ❑ Maintain weight
29. What was your lowest weight in the past 5 years? _____ lbs.
30. What was your highest weight in the past 5 years? _____ lbs.
31. What do you consider to be your ideal weight (the weight at which you feel best)? _____ lbs. ❑ Don't know

Exercise History

Answer the following as completely as possible. If you have any questions, DO NOT GUESS; ask your trainer for assistance. Thank you.

32. Please rate your exercise level on a scale of 1–5 (5 indicating very strenuous) for each age range through your present age:

    1–20 _____ 21–30 _____ 31–40 _____ 41–50 _____ 51–60 _____ 61–70 _____ 71 + _____

33. Were you a high school and/or college athlete? ❑ Yes ❑ No

    If yes, please specify: _____

34. Do you have any negative feelings toward or have you had any bad experience with physical activity programs? ❑ Yes ❑ No

    If yes, please explain: _____

    _____

35. Do you have any negative feelings toward or have you had any bad experience with fitness testing and evaluation? ❑ Yes ❑ No

    If yes, please explain: _____

    _____

36. Rate yourself on a scale of 1 to 5 (1 indicating the lowest value and 5 the highest) by circling the number that applies the most.

Characterize your present athletic ability:	1 2 3 4 5
When you exercise, how important is competition?	1 2 3 4 5
Characterize your present cardiovascular capacity:	1 2 3 4 5
Characterize your present muscular capacity:	1 2 3 4 5
Characterize your present flexibility capacity:	1 2 3 4 5

37. Do you start exercise programs but then find yourself unable to stick with them? ❑ Yes ❑ No
38. How much are you willing to devote to an exercise program? _____ minutes/day _____ days/week
39. Rate your perception of the exertion of your exercise program (circle the number):

    1 not currently exercising 2 light 3 fairly light 4 somewhat hard 5 hard

40. How long have you been exercising regularly? _____ months _____ years
41. Can you exercise during your work day? ❑ Yes ❑ No
42. Would an exercise program interfere with your job? ❑ Yes ❑ No

43. Would an exercise program benefit your job? ❑ Yes ❑ No

44. What types of exercise interest you?

❑ Walking ❑ Stationary biking ❑ Jogging ❑ Rowing
❑ Swimming ❑ Racquetball ❑ Dance exercise ❑ Cycling
❑ Tennis ❑ Strength training ❑ Stretching
❑ Other aerobic activities _____

Readiness to Change Questionnaire

	YES	NO
1. Are you looking to change a specific behavior?	❑	❑
2. Are you willing to make this behavioral change a top priority?	❑	❑
3. Have you tried to change this behavior before?	❑	❑
4. Do you believe there are inherent risks/dangers associated with not making this behavioral change?	❑	❑
5. Are you committed to making this change even though it may prove challenging?	❑	❑
6. Do you have the support for making this change from friends, family and loved ones?	❑	❑
7. Besides health reasons, do you have other reasons for wanting to change this behavior?	❑	❑
8. Are you prepared to be patient with yourself if you encounter obstacles, barriers, and/or setbacks?	❑	❑

I have answered the above questions to the best of my knowledge.

SIGNATURE PRINT NAME DATE (MM/DD/YY)

GENERAL RELEASE and ASSUMPTION OF RISK

In consideration of my using the Facilities and Equipment (both as hereinafter defined) located at Galter LifeCenter and of my participating in the Personal Training Program offered by LifeCenter on the Green, Inc., d/b/a Galter LifeCenter (hereinafter referred to as the "Program"), I HEREBY RELEASE, WAIVE AND FOREVER DISCHARGE LIFECENTER ON THE GREEN, INC., SWEDISH COVENANT HOSPITAL, THEIR AFFILIATES, THEIR DIRECTORS OR TRUSTEES, OFFICERS, EMPLOYEES, PERSONNEL, VOLUNTEERS, AND ANY OF THEIR INSTRUCTORS, AGENTS OR REPRESENTATIVES ("RELEASEES"), FROM ALL LIABILITY TO ME, MY SPOUSE, LEGAL REPRESENTATIVES, HEIRS AND ASSIGNS AND ANY PERSON CLAIMING THROUGH OR UNDER MYSELF OF AND FROM ANY AND ALL PRESENT AND FUTURE CLAIMS, DEMANDS, DAMAGES, ACTIONS, OR RIGHTS OF ACTION, WHETHER LEGAL OR IN EQUITY, ARISING FROM OR BY REASON OF ANY BODILY INJURY OR PERSONAL INJURIES KNOWN OR UNKNOWN, DEATH, LOSS OR THEFT OF PERSONAL PROPERTY OR PROPERTY DAMAGE THAT MAY OCCUR AS A RESULT OF MY PARTICIPATION IN THE PROGRAM, WHETHER RESULTING FROM THE NEGLIGENCE OF THE RELEASEES OR NOT.
Initial _____

I FURTHER HEREBY RELEASE, WAIVE AND FOREVER DISCHARGE RELEASEES FROM ALL LIABILITY TO ME, MY SPOUSE, LEGAL REPRESENTATIVES, HEIRS AND ASSIGNS AND ANY PERSON CLAIMING THROUGH OR UNDER MYSELF OF AND FROM ANY AND ALL PRESENT AND FUTURE CLAIMS, DEMANDS, DAMAGES, ACTIONS, OR RIGHTS OF ACTION, WHETHER LEGAL OR IN EQUITY, ARISING FROM OR BY REASON OF ANY BODILY INJURY OR PERSONAL INJURIES KNOWN OR UNKNOWN, DEATH, LOSS OR THEFT OF PERSONAL PROPERTY OR PROPERTY DAMAGE THAT MAY OCCUR IN, ON OR ABOUT THE GALTER LIFECENTER'S PREMISES OR AS A RESULT OF MY USING OR MISUSING THE FACILITIES, INCLUDING, BUT NOT LIMITED TO, THE NURSERY, AEROBIC STUDIO, POOL AREA AND RUNNING TRACK (THE "FACILITIES"), AND THE EQUIPMENT, INCLUDING, BUT NOT LIMITED TO, THE CARDIOVASCULAR AND EXERCISE WEIGHT EQUIPMENT, TREADMILLS, STATIONARY BICYCLES AND STAIR MACHINES (THE "EQUIPMENT"), AND/OR AS A RESULT OF MY PARTICIPATION IN THE PROGRAM, WHETHER RESULTING FROM THE NEGLIGENCE OF THE RELEASEES OR Not.
Initial _____

I understand and am aware that the physical exercise required by the Program, including the use of Equipment, is a potentially hazardous activity. I also understand that fitness activities involve a risk of injury and even death, and that I am voluntarily participating in these activities and using the Equipment with knowledge of the dangers involved. I HEREBY AGREE TO EXPRESSLY ASSUME AND ACCEPT ANY AND ALL RISKS OF INJURY, DAMAGES OR DEATH THAT MAY OCCUR TO ME IN, ON OR ABOUT THE GALTER LIFECENTER'S PREMISES, FACILITIES OR EQUIPMENT OR AS A RESULT OF MY PARTICIPATION IN THE PROGRAM.
Initial _____

I do hereby further declare myself to be physically sound and suffering from no condition, impairment, disease, infirmity, or other illness that would prevent my participation or use of the Equipment in connection with the Program except as hereinafter stated.
Initial _____

I further release the Releasees from any claim whatsoever on account of first aid treatment, emergency medical services or other services rendered to me during my participation in the Program.
Initial _____

I agree to indemnify and hold harmless the Releasees from and against all claims, demands, lawsuits, liabilities and costs (including reasonable attorneys' fees and court costs) brought or commenced by any person or entity for the recovery of damages for the injury, illness and/or death of any person or damage to property arising out of my negligent acts or omissions.

I expressly agree that this release and waiver agreement is intended to be as broad and inclusive as permitted by the law of the State of Illinois, and that if any portion thereof is held invalid, it is agreed that the balance shall, notwithstanding, continue in full legal force and effect.

I have read this agreement and fully understand that by signing this agreement, I am giving up legal rights and/or remedies which may be available to me.

Witness	Witness	Signature	
Print Name of Witness	Print Name of Witness	Print Name	Date

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For office use only Member #_____
Risk Stratification: ❑ Low ❑ Moderate ❑ High
❑ Fitness Consultation ❑ Fitness Orientation Date/Time of F/O _____
Is a doctor's note required? ❑ Yes ❑ No Staff Initials _____

HEALTH STATUS PRE-PARTICIPATION QUESTIONNAIRE

NAME DATE

PHONE EMAIL ADDRESS DATE OF BIRTH

Do you currently have a primary care physician? ❑ Yes ❑ No If yes, physician's name_____

Phone Number _____ Hospital Affiliation _____

If no, would you like to be referred to an SCH physician? ❑ Yes ❑ No

Mark all statements that apply to your current health condition to assess your health status.

History

Have you had:

- ❑ a 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
- ❑ taking heart medication
- ❑ unpleasant awareness of a forceful or rapid heart rate
- ❑ ankle swelling
- ❑ asthma or other lung disease
- ❑ burning or cramping sensation in your lower legs when walking short distances (claudication)
- ❑ diabetes

Are you currently pregnant? ❑ Yes ❑ No

Symptoms

Have you experienced:

- ❑ chest discomfort with exertion
- ❑ unreasonable breathlessness
- ❑ dizziness, fainting, or blackouts

If you marked any of these statements in the above two sections, **you are considered high risk and Galter LifeCenter requires** that you consult your physician and obtain medical clearance prior to engaging in physical activity. Other health issues may also require a physician's approval.

I have answered the above questions to the best of my knowledge.

Cardiovascular Risk Factors

- ❑ Age (Men ≥ 45/ Women ≥ 55)
- ❑ Family history (first degree relative, which includes biological father and mother and full, biological brothers and sisters, who have had heart attack(s) or heart surgery
- ❑ Current smoker or have quit within the last six months
- ❑ Physically inactive (< 30 minutes of physical activity at least three days per week)
- ❑ Body Mass Index ≥ 30
- ❑ Hypertension (blood pressure > 140/90 mm Hg)
  - ❑ blood pressure unknown
- ❑ Hypercholesterolemia (total cholesterol > 200 mg/dL)
  - ❑ cholesterol level unknown
- ❑ Prediabetes (fasting blood sugar >100)
  - ❑ prediabetes unknown

If you marked two or more of these statements **you are considered moderate risk and Galter LifeCenter highly recommends** that you participate in a fitness consultation/assessment and/or consult with your physician or other appropriate health care provider before engaging in physical activity.

❑ None of the above history, symptoms or risk factors

You should be able to exercise safely without consulting your physician or other appropriate health care provider in a self-guided program. However, Galter LifeCenter strongly recommends participating in a fitness consultation/ assessment and orientation in order to provide you with the best service and care.

Other Health Issues

- ❑ Musculoskeletal problems that limit physical activity (e.g. back pain, arthritis, tendonitis, etc.)
- ❑ Cancer
- ❑ Any other medical condition _____
- ❑ Take prescription medication(s), please list

_____

Comments: _____

SIGNATURE DATE