UCLA Recreation

UCLA Recreation personal training

Congratulations on your decision to invest in yourself! Our qualified, nationally certified personal trainers will provide you with the right information and the right training to help you achieve your goals. Before you get started with a personal fitness trainer, please follow the instructions detailed in the checklist below.

CHECKLIST

- Read and complete the following forms:
  - Participant Information (on back of this form)
  - Pre-participation Screening
  - Physician's Release (if necessary based on answers to Pre-participation Screening)
- **Submit the completed forms to the FITWELL Services desk *prior* to your first appointment**
- Look forward to your personal fitness trainer contacting you within 2 business days to set up your first appointment.
- Purchase session(s) at Sales & Cashiering, JWC 1st floor, or the FITWELL Services desk at KREC prior to your first appointment.
- Contact Amber Brown, Asst. FITWELL Program Director, at (310) 206-4924 or abrown@recreation.ucla.edu with any questions or concerns.

We look forward to helping you achieve your goals!

Healthy Regards,

FITWELL Services -JWC
2131 John Wooden Center
(310) 206-6130
(310) 825-6321 Fax
www.recreation.ucla.edu/pft

FITWELL Services -BFIT
251 Charles E Young Dr.
(310) 983-3064

www.recreation.ucla.edu/pft

UCLA Recreation

Date ____/____/____

Personal Fitness Training Program
Participant Information

First Name _____ **Last Name** _____

Bruincard ID # _____ ***or*** **Recreation Membership #** _____

Affiliation *(check one)* ☐ Student ☐ Recreation Member ☐ Non-Member ☐ Other: _____

Phone (_____)_____ **Cell Phone (_____)**_____

Email Address _____

Preferred Method of Communication *(check one)* ☐ phone ☐ email ☐ either

Preferred Location of Service *(check one)* ☐ JWC ☐ KREC ☐ either

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							
Afternoon							
PM							

Please detail your fitness and training goals.

Please briefly describe your current exercise routine.

Please list all prescription and non-prescription medications you are currently taking.

What is your occupation/work type? _____

Please list any injuries.

Please share any additional information that might be helpful in selecting a personal fitness trainer to meet your needs. (You may request a specific trainer here)

Staff Use Only

FW Name _____ **Date Received** ____/____/____

UCLA Recreation

Personal Fitness Training Program
Pre-participation Screening

☑ **Check all medical problems you have experienced within one year (unless indicated otherwise).**
Follow the instructions in each section.

Cardiovascular History

You have 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
- ☐ heart palpitations
- ☐ you take heart medications

Signs & Symptoms

- ☐ heart murmur
- ☐ You experience chest discomfort with exertion.
- ☐ You experience unreasonable breathlessness or fatigue with usual activities.
- ☐ You experience dizziness, fainting, blackouts.
- ☐ You have burning or cramping sensation in your lower legs when walking short distances.
- ☐ You have circulatory conditions like ankle swelling.
- ☐ You have ankle swelling not related to musculoskeletal injury.

Other Health Concerns

- ☐ You had a stroke or have cerebrovascular disease.
- ☐ You have diabetes or other metabolic disease.
- ☐ Your fasting blood glucose level is equal to or greater than 100 mg.
- ☐ You have asthma or other lung condition/disease
- ☐ You have a medical diagnosis or disease.
  Please indicate:_____
- ☐ You have musculoskeletal problems that limit your physical activity.
- ☐ You are pregnant.
- ☐ You have concerns about the safety of exercise.

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

Cardiovascular Risk Factors

You have had:

- ☐ You are a man 45 years of age or older.
- ☐ You are a woman 55 years of age or older, have had a hysterectomy, or are post menopausal.
- ☐ You smoke or quit smoking within the previous 6 months.
- ☐ Your blood pressure is greater than or equal to 140/90 mmHg or you do not know your blood pressure.
- ☐ You take blood pressure medication.
- ☐ Your blood cholesterol level is greater than 200 mg/dl or you do not know your cholesterol level.
- ☐ 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 (i.e, you get less than 30 minutes of physical activity on at least 3 days per week).
- ☐ You are more than 20 pounds overweight.

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

☐ **I DO NOT have any cardiovascular history, signs or symptoms, cardiovascular risk factors or other health concerns:**

Signature:_____ Date:_____

UCLA Recreation

Date: ___/___/___

Personal Fitness Training Program
Physician's Release

Dear Doctor:

Your patient _____ wishes to start a personalized training program through the UCLA Recreation Personal Fitness Training Program. Exercise recommendations provided by the trainer will start easy and become progressively more intense depending on the client's goal and fitness level. Qualified staff will administer all fitness assessments and exercise.

If you know of any medical or other reasons why participation in the program by the client would be unwise, please indicate so on this form.

Report of Physician

_____ I know of no reason why the applicant may not participate.

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

_____

_____

_____

*My patient is taking medications that will affect heart rate response to exercise. The effects are indicated below:

Type of medication _____

*Effect*_____

*Restrictions for exercise*_____

_____ The client should not engage in the following activities:

_____

_____

_____

_____ I recommend that the client NOT participate.

Physician Signature: _____ Date: _____/_____/_____

Print Name: _____ Phone: _____

Thank You.

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