TRAIN WITH JANE

DR. JANE RILEY, Ed.D, MS, BA

CERTIFIED PERSONAL FITNESS TRAINER

CERTIFIED NUTRITION CONSULTANT

CERTIFIED BEHAVOR CHANGE SPECIALIST

CONFIDENTIAL HEALTH SCREEN FORM

Name (print) _____ Signature_____ Date_____ Age_____

Male ___ Female___ Height _____ Weight _____Phone # _____ Email_____

This form is intended to obtain relevant information about your health to assist in the creation of an effective health program. This form accompanies a waiver of liability. Please answer all questions truthfully and to the best of your knowledge. Ask questions if you are unsure.

Weight: Is your current body weight.... Underweight? ____ (5 **pounds less** than ideal?) Normal? _____ 5-10 overweight? _____ 10 to 20 pounds overweight? _____ More than 20 pounds overweight? ____? What is your weight goal? _____

Blood Pressure: Do you have high blood pressure? YES ____ NO _____ Have you had a history of high blood pressure? YES____ NO ____ Are you on medication for high blood pressure? YES ____ NO _____ Do your ankles swell? YES____ NO____

Smoking: Do you smoke? YES____ NO____ How much do you smoke? _____
Are you a former smoker? YES_____ NO____ When did you quit smoking? DATE_____

Diabetes: Do you have Diabetes? YES____ NO___ Is there a family history of Diabetes? YES___ NO____

Heart Problems: Have you ever had a heart attack? YES____NO____ Have you ever had Heart Surgery? YES___ NO___ Have you ever suffered from ANGINA? (Heart pain) YES____ NO___

Family History: Have any of your relatives had heart disease, heart surgery or angina? YES____ NO____
Do any of your family suffer from any other inherited predispositions YES____ NO____
What conditions run in your family?_____

Orthopedic Problems: Do you have any serious orthopedic problems that would prevent you from exercising? YES _____ No _____ What joint issues do you have? _____
What structural issues do you have? _____

Other Problems? : Do you have reason to believe that you should not exercise?_____
Has your Doctor given you clearance to exercise?_____

Emergency Contact Information: Name of contact: _____ Phone #_____

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Exercise and exercise equipment have inherent risks. I the undersigned recognize and accept **ALL** risk of bodily injury, property loss or damage.

I assume **ALL** responsibility for any loss, damage or injury suffered by me as a result of participation in any exercise regime, nutritional guidance or behavior change work or therapeutic touch work directed or administered by Jane Riley.

I hold Jane Riley , her heirs, and estate, faultless in any claim , and relinquish any legal rights should any loss, damage or injury befall me subsequent to any advice or action given by Jane Riley or agents of TRAIN WITH JANE. This clause is in effect **regardless** of how such loss or injury or damages may be caused.

I have completed a **HEALTH SCREEN FORM** which accompanies this waiver of liability and have clearly and honestly indicated **any** and **all** conditions or limitations which may affect my participation in a nutritional, exercise, stress reduction or behavioral change intervention.

I acknowledge that unless **24 hours' notice** of cancellation or re-scheduling of an appointment is received and acknowledged by Jane Riley, any scheduled appointment will be deemed as earned and will be charged accordingly. This clause applies to all sessions missed without adequate notice.

Signature_____ Emergency contact_____

Street Address_____ Email contact _____

City, ZIP, _____ Date_____

Phone _____ Witness_____

DATE YEAR MONTH DAY

NAME OF APPRAISER

Gender ❑ M ❑ F

ame of Client

Age

ysician: Phone:

xt of Kin: Phone:

IMARY GOAL:

RE-TEST SCREENING

R-Q

	Screened YES	NO
Has your doctor ever said that you have a heart condition and that you should only do physical activity recommended by a doctor?	❑	❑
Do you feel pain in your chest when you do physical activity?	❑	❑
In the past month, have you had chest pain when you were not doing physical activity?	❑	❑
Do you lose your balance because of dizziness or do you ever lose conciousness?	❑	❑
Do you have a bone or joint problem that could be made worse by a change in your physical activity?	❑	❑
Is your doctor currently prescribing drugs (for example, water pills) for your blood pressure or heart condition?	❑	❑
Do you know of any other reason why you should not do physical activity?	❑	❑

ed consent form:

❑ Signed ❑ Not Signed → ❑ ❑

ERVATIONS

ancy – ask all females	❑	❑
ulty breathing at rest	❑	❑
stant cough	❑	❑
extremity swelling	❑	❑
ntly on medication	❑	❑
red preliminary instructions:	❑	❑

❑ Followed ❑ Not Followed → ❑ ❑

❑ ❑

THY PHYSICAL ACTIVITY STIONNAIRE

Score: _____

Rating: _____

ASTIC LIFESTYLE STIONNAIRE

Score: _____

Rating: _____

RESTING HEART RATE AND BLOOD PRESSURE

HEART RATE 15 sec [ ] bpm [ ]

SYSTOLIC mm Hg [ ] DIASTOLIC mm Hg [ ]

If reading heart rate ≥ 100, or systolic > 144, or diastolic > 94, have client rest 5 minutes and then repeat measurements.

			YES	NO
HEART RATE	15 sec [ ]	bpm [ ]	HR ≥ 100	❑ ❑
SYSTOLIC	mm Hg [ ]		Systolic > 144	❑ ❑
DIASTOLIC	mm Hg [ ]		Diastolic > 94	❑ ❑

ANTHROPOMETRIC MEASUREMENTS

		Healthy	Unhealthy
WEIGHT (kg)	[ ]		
HEIGHT (cm)	[ ]		
BMI (kg/m²)	[ ]	H ❑	UH ❑
WAIST GIRTH (cm)	[ ]	H ❑	UH ❑

SKINFOLDS (mm)

			Mean Closest
Triceps	1st	[ ]	[ ]
	2nd	[ ]	
	3rd	[ ]	
Biceps	1st	[ ]	[ ]
	2nd	[ ]	
	3rd	[ ]	
Subscapular	1st	[ ]	[ ]
	2nd	[ ]	
	3rd	[ ]	
Iliac Crest	1st	[ ]	[ ]
	2nd	[ ]	
	3rd	[ ]	
Medial Calf	1st	[ ]	[ ]
	2nd	[ ]	
	3rd	[ ]	

HEALTHY BODY COMPOSITION

		H	UH
SO5S: Sum of (5) Skinfolds	[ ]	❑	❑
SO2S: Sum of (2) Trunk Skinfolds	[ ]	H ❑	UH ❑

BMI and SO5S: _____ points Score: _____

WG and SO2S. _____ points Rating: _____

AEROBIC FITNESS

modified CANADIAN AEROBIC FITNESS TEST (mCAFT)

STARTING STAGE [ ]

Count Method Used:
❑ palpation or oscillation (10 sec)
❑ Heart Rate Monitor (bpm)

Heart Rate	1st session	[ ]
	2nd session	[ ]
	3rd session	[ ]
	4th session	[ ]
	5th session	[ ]
Heart Rate Final (bpm)		[ ]

HEALTHY AEROBIC FITNESS

Score: _____

Rating: _____

POST EXERCISE

Blood Pressure	2:00 - 2:30 min.	Systolic	mm Hg [ ]
		Diastolic	mm Hg [ ]
	3:30 - 4:00 min.	Systolic	mm Hg [ ]
		Diastolic	mm Hg [ ]
Heart Rate	4:00 - 4:30 min.		bpm [ ]

MUSCULO-SKELETAL FITNESS

GRIP STRENGTH (kg)

Right Hand	1	[ ]	
	2	[ ]	Max [ ]
Left Hand	1	[ ]	
	2	[ ]	Max [ ]

Combined Right and Left Max [ ]

PUSH-UPS Rating: _____

Max Number [ ] Rating: _____

TRUNK FORWARD FLEXION (cm)

Trial 1 [ ]

Trial 2 [ ] Max [ ] Rating: _____

PARTIAL CURL-UP

(Maximum 25) [ ] Rating: _____

VERTICAL JUMP

Stand and Reach (cm) [ ]

Jump Trial	1	[ ] cm	
	2	[ ] cm	
	3	[ ] cm	Max difference [ ]

Rating: _____

Leg Power [ ] kgm/sec Rating: _____

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Date	Workout	Nutrition	Relaxation

Additional comments_____

CANCELLATION POLICY

Our rates and scheduling requirements do not permit deviation

When you provide at least 24-hour notice that you must cancel an appointment, the session can be rescheduled for a later time.

If you give less than 24-hour notice, the fee for the scheduled services will be deemed *earned*.

I respect the value of your time and will honor each scheduled appointment regardless of my circumstances. If for any unforeseen reason, I *must* reschedule a session with less than a 24-hour notice to you, that session, *plus*, one free session will be scheduled at your convenience.

As a practical matter, we regret being unable to make exceptions for sudden illness, personal emergencies or family exigencies.

Pledging my unwavering support for your fitness objectives.

Jane