

JCC PERSONAL TRAINING INQUIRY

MEMBER NAME _____ DATE _____

ADDRESS _____

E-MAIL _____

PHONE home _____ work _____ cell _____

BEST TIME TO CALL _____ BEST NUMBER TO CALL (circle one) home work cell

TRAINER PREFERENCES (circle your preferences)

TRAINER GENDER Male Female No Preference

SESSION TIME Morning Afternoon Evening Anytime

SPECIFIC TIME AM 6:00 7:00 8:00 9:00 10:00 11:00

PM 12:00 1:00 2:00 3:00 4:00 5:00 6:00 7:00 8:00

SPECIFIC DAY: Saturday Sunday Monday Tuesday Wednesday Thursday Friday

I PREFER TO TRAIN WITH (name of trainer) _____

ADDITIONAL INFORMATION _____

CONTRACT INFORMATION:

1. Cancelling a session requires 24-hour notice or the client will be charged for a session.
2. All training sessions must be used within 3 months for 10 sessions or 5 months for 20 sessions (etc) from the date sessions are purchased.

CLIENT SIGNATURE _____

DATE _____

Please return Inquiry and Medical History forms to:

UPTOWN: Katie Kiefer, Wellness Director - Uptown, at 504-897-1380 (fax) or
5342 St. Charles Avenue, New Orleans, LA 70115

METAIRIE: Denise Thornton, Wellness Director- Metairie, at 504.780.5639 (fax) or
3747 West Esplanade Avenue, Metairie, LA 70002



MEDICAL HISTORY

CLIENT NAME _____ AGE _____

CHECK ALL THAT APPLY

- Recent illness, hospitalization or surgical procedure
- Heart attack, coronary bypass, cardiac surgery, stroke
- Abnormal resting or stress ECG
- Uneven, irregular, or skipped heart beats (including a racing or fluttering heart)
- Abnormal blood lipids (total cholesterol, HDL, LDL, triglycerides)
- Family history of coronary or other atherosclerotic disease prior to age 55 male, 65 female
- Diabetes Mellitus (type I, type II, or gestational)
- High blood pressure
- Phlebitis Emboli
- Pulmonary disease (asthma, emphysema, and bronchitis)
- Rheumatic Fever
- Light-headedness or fainting
- Chest pain at rest or exertion
- Unusual shortness of breath
- Orthopedic problems (arthritis or any other bone, joint, or muscle problems)
- Emotional disorders
- Medications
- Drug allergies
- Smoking
- Physical inactivity

RECOMMENDATIONS/HEALTH STATUS CLASSIFICATION

- | | |
|--|---|
| <input type="checkbox"/> Medical clearance | <input type="checkbox"/> Apparently healthy |
| <input type="checkbox"/> Max stress test and medical clearance | <input type="checkbox"/> Increased risk |
| <input type="checkbox"/> Refer to medically supervised program | <input type="checkbox"/> Known disease |

COMMENTS

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