Client Information

Name_____
Address_____
Phone_____
Email_____
Emergency Contact_____
Emergency Phone_____

Pretest Instructions for a Fitness Test

Name _____ Test date _____ Time _____
Report to _____
Instructions
Please observe the following:
1. Wear running shoes, shorts, and a loose-fitting shirt.
2. No food, drink (except water), tobacco, or medication for 3 hr before test.
3. Minimize physical activity on day of test.
Cancellation
If you cannot keep this appointment, please call _____ or _____.

Informed Consent for Fitness Test Participation

Testing objectives: In order to more safely participate in an exercise program, I hereby consent, voluntarily, to a series of exercise tests. Each test will assist in the determination of my overall physical fitness and will assess the following: cardiovascular fitness, body composition, muscular strength and endurance, and flexibility. I shall perform a graded exercise test (GXT) by walking on a treadmill or riding a cycle ergometer. The GXT will begin at a low level and gradually increase in difficulty until my target heart rate is achieved. The test may be stopped at any time because of feelings of significant fatigue or for any other personal reason. Body composition will be determined using skinfold tests. Muscular strength and endurance will be assessed with proper resistance training equipment. A sit-and-reach test will ascertain the flexibility of the hip joint.

Risk and discomforts: I understand that the risks of the GXT or other test procedures may include abnormal heart rhythms, abnormal blood pressure response, fainting, and very rarely a heart attack. Every professional effort will be made to minimize these risks through proper administration of a completed health status questionnaire (HSQ) as well as assessment of relevant health questions and supervision during the tests.

Responsibilities of the participant: I acknowledge that I have completed the HSQ and answered any attendant health questions accurately. During the GXT or other tests, I will report any heart-related symptom (i.e., pain, pressure, tightness, or heaviness in the chest, neck, jaw, back, or arms) immediately. I have reported all medications (including nonprescription medications) taken on a regular basis, including today, to the appropriate staff member.

Benefits to be expected: I desire to pursue a GXT and additional fitness tests so that I may obtain better advice regarding my present level of cardiovascular fitness and overall physical fitness. This information will be used to prescribe an appropriate individualized exercise program. I understand that this test does not entirely eliminate risk in the proposed exercise program.

Inquiries: I understand that I can withdraw my consent or discontinue participation in any aspect of the fitness testing at any time without penalty or prejudice toward me. I have read the above statements and have had all of my questions answered to my satisfaction.

Use of medical records: I have been informed that the information obtained from the fitness tests is privileged and confidential as described in the Health Insurance Portability and Accountability Act of 1996. It will not be disclosed to anyone other than my physician or individuals responsible for designing and supervising my exercise program, without my express written permission.

_____ _____

Signature of participant / Date

_____ _____

Signature of witness / Date

Physical Activity Readiness Questionnaire (PAR-Q)

PAR-Q is designed to help you help yourself. Many health benefits are associated with regular exercise, and the completion of PAR-Q is a sensible first step to take if you are planning to increase the amount of physical activity in your life.

For most people, physical activity should not pose any problems or hazard. PAR-Q has been designed to identify the small number of adults for whom physical activity might be inappropriate or those who should have medical advise concerning the type of activity most suitable for them.

Common sense is your best guide in answering these few questions. Please read the carefully and check **YES** or **NO** opposite the question if it applies to you. If yes, please explain.

YES **NO**

____ ____ 1. Has your doctor ever said you have heart trouble?

Yes, _____

____ ____ 2. Do you frequently have pains in your heart and chest?

Yes, _____

____ ____ 3. Do you often feel fain or have spells of severe dizziness?

Yes, _____

____ ____ 4. Has a doctor ever said your blood pressure was too high?

Yes, _____

____ ____ 5. Has your doctor ever told you that you have a bone or joint problem(s), such as arthritis that has been aggravated by exercise, or might be made worse with exercise?

Yes, _____

____ ____ 6. Is there a good physical reason, not mentioned here, why you should not follow an activity program even if you wanted to?

Yes, _____

____ ____ 7. Are you over age 60 **and** not accustomed to vigorous exercise?

Yes, _____

____ ____ 8. Do you suffer from any problems of the lower back, i.e., chronic pain, or numbness?

Yes, _____

____ ____ 9. Are you currently taking any medications? If YES, please specify.

Yes, _____

____ ____ 10. Do you currently have a disability or a communicable disease? If YES, Please specify,

Yes, _____

If you answered NO to all questions above, it gives a general indication that you may participate in physical and aerobic fitness activities and/or fitness evaluation testing. The fact that you answered NO to the above questions, is no guarantee that you will have a normal response to exercise. If you answered Yes to any of the above questions, then you may need written permission from a physician before participating in physical and aerobic fitness activities and/or fitness evaluation testing at the Winona State Fitness Center.

_____ _____ _____

Print Name Signature Date

Health Status Questionnaire

This questionnaire identifies adults for whom physical activity might be inappropriate or adults who should seek physician consultation before beginning a regular physical activity program.

Section 1 Personal and Emergency Contact Information

Name: _____ Date of birth: _____
Address: _____ Phone: _____
Physician's name: _ _____ Height: _____
_ _____ Weight: _____
Person to contact in case of emergency_____
Name:_____ Phone: _____

Section 2 General Medical History

Please check the following conditions you have experienced.

Heart History

_____ Heart attack _____ Cardiac rhythm disturbance
_____ Heart surgery _____ Heart valve disease
_____ Cardiac catheterization _____ Heart failure
_____ Coronary angioplasty (PTCA) _____ Heart transplantation
_____ Cardiac pacemaker _____ Congenital heart disease

Symptoms

_____ You experience chest discomfort with exertion.
_____ You experience unreasonable shortness of breath at any time.
_____ You experience dizziness, fainting, or blackouts.
_____ You take heart medications.

Additional Health Issues

_____ You have asthma or other lung disease (e.g., emphysema).
_____ You have burning or cramping sensations in your lower legs with minimal physical activity.
_____ You have joint problems (e.g., arthritis) that limit your physical activity.
_____ You have concerns about the safety of exercise.
_____ You take prescription medications.
_____ You are pregnant.

Section 3 Risk Factor Assessment

Risk Factors for Coronary Heart Disease

_____ You are a man older than 45 yr.
_____ You are a woman older than 55 yr, have had a hysterectomy, or are postmenopausal.
_____ You have diabetes (type 1 or type 2).
_____ You smoke or you quit smoking within the previous 6 mo.
_____ Your blood pressure is >140/90 mmHg.
_____ Your blood cholesterol is >200 mg · dl^{-1}.
_____ You have a close male blood relative (father or brother) who had a heart attack or heart surgery before the age of 55 or a close female blood relative (mother or sister) who had a heart attack or heart surgery before the age of 65.
_____ You are physically inactive (you get <30 min of physical activity at least 3 days per wk).

_____ Your waist circumference is >40 in. (101.6 cm) if you are a man or >35 in. (88.9 cm) if you are a woman.

Section 4 Medications

Are you currently taking any medication?_____ Yes _____No
If yes, please list all of your prescribed medications and how often you take them, whether daily (D) or as needed (PRN).

_ _____
Of the medications you have listed, are there any you do not take as prescribed?_____
_ _____

Section 5 Physical Activity Patterns and Objectives

List the type, frequency, intensity (e.g., low, moderate, strenuous), and duration of your weekly exercise. _____
_ _____
_ _____
List your specific goals for your exercise program. _ _____
_ _____

Please inform the fitness professional immediately of any changes that occur in your health status.

Patient Information Release Form

If you have answered yes to questions indicating that you have significant cardiac, pulmonary, metabolic, or orthopedic problems that may be exacerbated with exercise, you agree that it is permissible for us to contact your physician regarding your health status.

Signature:_____ Date:_____
Fitness staff signature:_ _____ Date:_____
To be completed by fitness professional (circle one):
AHA/ACSM risk stratification: Low Moderate High Physician consent: Yes No

Fitness Assessment Data Sheet

Tester Name_____

Pretest Assessment

Gender _____ Age _____

Height _____ in. _____ cm Weight _____lb _____ kg

Resting blood pressure _____mmHg Resting heart rate_____ beats · min^{-1}

Client Program Goals

Circle as many as apply:

Aerobic fitness Weight management Muscular endurance or strength

Other (explain) _____

Body Composition: Skinfold Assessment

Record the sum of 3 skinfold sites in mm (av = average).

Male:

Chest ____ ____ av. ____ Abdomen ____ ____av. ____ Thigh ____ ____ av.____

Female:

Triceps ____ ____ av.____ Suprailiac ____ ____ av.____ Thigh ____ ____ av.____

(av = average the two sites)

Sum of 3 sites _____ mm

_____ % fat Percentile (rank) _____

Girth Measurement: Waist-to-Hip Ratio

Waist ____ ____ av. ____ Hips____ ____ av. ____ WHR_____

Cardiorespiratory Testing

Protocol _____

Predicted max heart rate_____ beats · min^{-1}

85% max predicted heart rate_____ beats · min^{-1}

1.
2.
3.
4.
5.

Cool-down (min)

Maximal oxygen consumption _____ ml · kg^{-1} · min^{-1}

Percentile (rank) _____

Muscular Fitness Testing

Upper-Body Muscular Endurance

Choose one test:

Push-up test _____ push-ups

Percentile (rank) _____

OR

Bench press test _____ repetitions

Percentile (rank) _____

Abdominal Endurance

Curl-up (crunch) test _____ curl-ups

Percentile (rank) _____

Flexibility Testing

Sit-and-reach test (1)_____ (2) _____ (3) _____

Best score _____ in./cm (circle one)

Percentile (rank) _____