TRAC BOOT CAMP INFORMATION SHEET

Our Boot Camp Challenge will be a 6 week program starting on May 16th and will comprise of the following:

May 16th	Initial team meeting
	Beginning evaluations including body composition, weigh in, physical assessment
May 20 - June 27	6 week program includes
	2 group workouts per week
	Additional mindset and dietary coaching
	Guided weekly plans provided by trainers
May 30 - July 2	Final evaluations

Last Name_____First Name_____M.I. _____

Birth Date / / Gender M or F Height_____Weight _____

Address_____

How did you hear about our Program? _____

Have you ever trained with us? When? _____

Phone _____Email _____

How do you prefer to be contacted? Phone Email

EMERGENCY CONTACT _____

EMERGENCY PHONE # _____

Do you currently perform any type of physical activity? Yes No

If yes, how often (circle one)?

1 time/week 2-3 times/week 4-5 times/week Daily

What part of the day would you like to train? Morning Afternoon Night

What are your health and fitness goals? Circle all that apply

Weight Loss Increase Cardiovascular Endurance Increase Strength Increase Flexibility

Increase Energy Improve Posture Enhance Athletic Performance Stress Management

Other: _____

Additional Comments: _____

_____

TRAC BOOT CAMP INFORMED CONSENT

My participation in the Two Rivers Activity Center Elite Training is voluntary and I may withdraw from the evaluation or program at any time. The benefits associated with my participation include information regarding my personal state of fitness and the increase of my physiological knowledge.

I HEREBY CONSENT TO and PERMIT Two Rivers Activity Center staff to use my testing data obtained in report or publications, but my identity will not be associated with such reports unless I have given specific permission to do so.

I understand that these evaluation(s) and program participation should not result in physical injury to me. However, I acknowledge the following:

In the event of physical injury, initial first aid will be provided. If further medical attention is needed I must look to my own health insurance policies for further medical assistance.

I understand the Two Rivers Activity Center staff is relying on all information provided by me regarding my medical history and condition before allowing me to participate in any evaluation or training program. I certify the information to be true and correct.

_____ _____

Client Signature Date

HEALTH HISTORY QUESTIONNAIRE

PLEASE PRINT

Name: Age: Date of Birth:

Street Address: City: State: Zip:

Home Phone: Work #:: email:

Physician: Clinic: Phone:

Emergency Contact Name: Relationship: Phone

Please complete the following by marking a check mark in the "YES" or "NO" column:

Past Personal Health History RISK FACTORS			**FAMILY HISTORY**			**PRESENT SIGNS & SYMPTOMS**		
Gender /Age Male ≥ 45	yes	no	**Has your mother, father. sister or brother had:**	yes	no	**Have you recently experienced any of the following symptoms over the past 3 months?**	yes	no
Female ≥ 55	yes	no						
Mark all that apply to you (diagnosis or behavior):	yes	no						
Heart Attack / Heart Disease	____	____	Heart Attack / Heart Disease before age 55 male or			Undiagnosed chest, jaw, or neck pain or discomfort	____	____
Heart Operation	____	____	before age 65 female	____	____	Shortness of breath @ rest		
Stroke	____	____	Heart By Pass / Stent/PTCA	____	____	or with mild exertion	____	____
Diabetes	____	____	High blood pressure	____	____	Ankle Swelling	____	____
Lung Disease / COPD	____	____	Stroke	____	____	Known heart murmur	____	____
Asthma	____	____	Diabetes	____	____	Blockage in leg arteries	____	____
High Blood Pressure	____	____	Early death in family due to			Heart palpitations	____	____
Smoke Cigarettes	____	____	heart disease – before age			Dizziness / fainting	____	____
High Cholesterol	____	____	55 male or age 65 female	____	____	Frequent headaches	____	____
Fasting glucose ≥ 110	____	____				Back Pain	____	____
BMI ≥ 30	____	____				Muscle Injury	____	____
Live Sedentary lifestyle	____	____				Bone/ joint injury or		
Waist >35 women >40 men						surgery		

Current Diagnosis: _____

Describe any bone / joint / muscle conditions: Fibromyalgia / Arthritis / Disc Injury Knee / Hip / Shoulder

_____

_____

Staff Comments: **Low Risk** **Moderate Risk** **High Risk**

_____

_____

_____

_____

Has participant discussed starting exercise program with physician? _____

_____

HEALTH HISTORY QUESTIONNAIRE LIFESTYLE BEHAVIORS / TEST RESULTS

SMOKING HISTORY

1) Do you currently smoke cigarettes? Yes No
   How many packs per day _____ # of years: _____
2) Are you a past smoker? Yes No
   Your quit date: _____How long did you smoke (in years): _____ How many packs/day:_____
3) Do you use chewing tobacco? Yes No
   Do you smoke Cigars? Yes No
   Are you exposed to Second hand smoke? Yes No
4) Pack years:_____ (years smoked x pack per day)
5) Do you want to quit? Yes No Unsure

CHOLESTEROL RESULTS

Have you had a cholesterol test recently? Yes No
If yes, was it: normal high don't know
If you know your numbers, complete the following:

Total Cholesterol _____
HDL Cholesterol _____
LDL Cholesterol _____
Ratio TC/HDL _____
Triglycerides _____

ACTIVITY LEVEL

1) Are you currently participating in a regular fitness program (walking, biking, dance, etc)? Yes No
   If yes, what activity: _____
   How many days/week? _____ how long? _____min
   If no, when was the last time you got regular physical activity? _____
2) Does your job require physical activity? Yes No
   If yes, explain: _____
3) Do you participate in physically active recreational activities (volleyball, softball, etc)? Yes No
   If yes, what kind? _____
   How many days/week? _____How long? _____min
   Home Exercise Equipment _____

CONSUMPTION OF CAFFEINE / ALCOHOL:

List quantity consumed per week:
Cups of Coffee _____ Cups of Tea _____
Cans of soda pop _____ diet_____ regular ____
Cans of Beer _____ Glasses of Wine _____
Liquor Drinks _____ Other: _____

Please list all medication taken regularly – either over the counter or prescription:

MEDICATION	PURPOSE	DOSAGE	FOR HOW LONG?
MEDICATION ALLERGIES?			

What are your goals for participating in this program? _____

_____

Please list any other medical conditions, special instructions or limitations not already identified:

_____

_____

_____

_____

I understand that it is important that I provide complete and accurate responses to the Health History Questionnaire and recognize that my failure to do so could lead to possible unnecessary injury to myself during the fitness program.

_____ _____
Signature Date

_____ _____
Staff Signature Date