Inspirit Self Training
Encouragement. Knowledge. Power.

Date:

Registration and Pre-Participation Interview

All personal information is strictly confidential. The information we collect is used only to serve and communicate with you. Your information will never be shared with other organizations for commercial purposes.

Pages 1-2 are required for registration. Pages 3-7 contain questions that will help us personalize your training program. More information will improve your experience. Please provide as much information as you are comfortable with.

Please bring your completed form to your first session or email your completed registration form to **registration@learntoworkout.com**. ***Thank you!***

Personal Information

First Name:	Middle Initial:	Last name:
Street address:		Apt./Unit #:
City:	State:	Zip:

Marital status: ☐ Single ☐ Divorced/separated ☐ Widowed ☐ Married

If married: Spouse name Spouse phone:

Your Date of Birth:	Height:	Current Weight:	Weight at age 21:

Did you review, answer and sign the PAR-Q health screening form? ☐ No ☐ Yes

Did you honestly answer "no" to all questions on the PAR-Q? ☐ No ☐ Yes

If you answered "yes" to any of the PAR-Q questions, do you have a signed medical clearance form from your doctor? ☐ No ☐ Yes

Workout Plans

I plan to workout ☐ At home ☐ At a gym ☐ Not sure ☐ Other

Contact Information

Home phone:	Mobile phone:
Work phone:	Other phone:

Preferred phone contact: ☐ Home ☐ Work ☐ Mobile ☐ Other

E-mail address: Home:	Work:

May we e-mail you regarding program related information? ☐ No ☐ Yes

Preferred e-mail contact: ☐ Home ☐ Work ☐ Do not contact me via e-mail

Emergency Contact Information

In case of emergency, please contact:

First Name:	Last name:	Relationship:
Street address:		Apt./Unit #
City:	State:	Zip:
Primary phone:	Alternate phone:	

Registration

Please register me for the following:

Course #	Course Name	Fee	Start Date	Day	Time
☐ **FF1**	**Fast Fx Strength Training**	**$660**			
☐ **FC2**	**Be Flexible and Get the Most From Your Cardio**	**$85**			
☐ **FW3**	**Win the Food War Without A Fight**	**$85**			
☐ **FU4**	**Follow Up Practice-Upper Body**	**$40**			
☐ **FL5**	**Follow Up Practice-Lower Body**	**$40**			
☐ **AL5**	**The All-In-One Course**	**$820**			
	Consultation/Individual Training	**$75p/hr**			

Method of payment:

☐ **Cash**
☐ **Check**
☐ **Credit card online through Paypal**

- I understand if I register for a specific course day and time my space in the class is reserved when I pay for the course.
- I understand after I pay for a course no refunds will be given.
- I understand if I purchase a course program, there are no refunds for missed classes.

Signature _____ Date _____

☐ I am submitting my registration form electronically. By checking this box I am signing this form.

Goals and Expectations

1. Please check each item that is important to you:

☐ 1. Improve Strength	☐ 4. Fat Loss	☐ 7. Reduce Stress	☐ 10. Injury Prevention	☐ 13. Body Building
☐ 2. Improve Flexibility	☐ 5. Build Muscle	☐ 8. Increase Energy	☐ 11. Reduce Back Pain	☐ I4. Sports Performance
☐ 3. Improve Fitness	☐ 6. Tone-Up	☐ 9. Improved Function	☐ 12. Injury Rehabilitation	☐ 15. Other

Which one is most important to you?

2. Specifically, what would you like to accomplish in the next 2 months? In the next 6 months? In the next year?

3. In what way do you expect an exercise training program to help you achieve your goals?

4. How much time would you like to commit to your goals? What is a realistic schedule based on other commitments?

5. On a scale of 1 to 10 (1=low and 10=high), please rate your current level of commitment to achieving your goals.

(low) ☐1 ☐2 ☐ 3 ☐4 ☐5 ☐ 6 ☐ 7 ☐ 8 ☐9 ☐10 *(high)*

Additional comments about your goals:

Occupation and Stressors

1. **What is your present occupation?**

2. **Does your occupation require much activity (standing, walking, getting up and down, carrying things)?**

3. **How much time do you spend in a seated position?**

4. **How many hours each day do you spend in front of a computer?**

5. **What types of things make you feel stressed?**

6. **On a scale of 1 to 10, (1=no stress, 10= a lot of stress), please rate the amount of stress in your career.**

   (low) ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 *(high)*

7. **On a scale of 1 to 10, (1=no stress, 10= a lot of stress), please rate the amount of stress in your personal life.**

   (low) ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 *(high)*

8. **How do you normally deal with your stress?**

9. **Do you feel any friends, coworkers or family members may have negative feelings about your exercise program?**

10. **Is there anyone in your work, family or social life that you think will be especially supportive of your exercise program?**

Leisure and Exercise History

1. Are you currently involved in an exercise program? ☐ No (skip to question #2) ☐ Yes

☐ **Cardiovascular/aerobic/continuous exercise (walking, running, biking etc.)**

How often? _____ times per week **How long each session?** _____ minutes **Type?** _____

☐ **Strength training** **How often?** _____ times per week **How long each session?** _____ minutes

Type? ☐ Strength machines ☐ Free weights ☐ Bands/other resistance ☐ Stability/core training ☐ Plyometrics

☐ **Other** _____ **How often?** _____ times per week **How long each session?** _____ minutes

2. In the past year, how often have you engaged in physical activity?

☐ Regularly (3-4 times p/wk) ☐ Semi-Regular (1-2 times p/wk) ☐ Sporadic (1-2 times per month) ☐ None

3. Do you know these exercises? Check the box if you are familiar with the exercise.

☐ Bicep curls ☐ Triceps Kickbacks ☐ Triceps extensions ☐ Shoulder press ☐ Lateral raise ☐ Front raise
☐ Dumbbell flye ☐ Bench press ☐ One arm-row ☐ Shrugs ☐ Upright row ☐ Squats ☐ Lunges ☐ Step-ups
☐ Deadlifts ☐ Hamstring Curls ☐ Calf raise ☐ Crunches (abs) ☐ Bicycles (abs) ☐ Cross-overs (abs)

4. Can you comfortably perform 30 minutes of vigorous continuous exercise, such as walking or running?

☐ No ☐ Yes

5. Please rate yourself on a scale of 1 to 5 (one is low, five is high)

Current cardiovascular capability	☐ 1 (low)	☐ 2	☐ 3	☐ 4	☐ 5 (high)
Present muscular strength	☐ 1 (low)	☐ 2	☐ 3	☐ 4	☐ 5 (high)
Present flexibility	☐ 1 (low)	☐ 2	☐ 3	☐ 4	☐ 5 (high)
Your current athletic ability	☐ 1 (low)	☐ 2	☐ 3	☐ 4	☐ 5 (high)
How important competition is to you	☐ 1 (low)	☐ 2	☐ 3	☐ 4	☐ 5 (high)

6. Do you have any other formal exercise experience? (i.e. leagues, classes, personal training, etc.)

What type?

Were you a high school or college athlete? ☐ No ☐ Yes Which sport(s)? _____

7. Are there any sports that you currently enjoy?

8. What type of physical activity have you been successful with in the past?

9. What are your personal barriers to exercise? What, if anything, gets in your way?

10. If you have any concerns about exercise or starting this training program, what are they?

Injuries, Pain and General Health

1. Please check any of the following injuries you've had and specify which bone, muscle, joint, etc., was affected and the year the injury occured:

Type of Injury	Describe	What year?
Broken bones		
Tears, Sprains and Strains ☐ Muscles ☐ Ligament ☐ Tendon ☐ Cartilage		
Back injury		
Nerve entrapment (e.g. carpal tunnel syndrome)		
Other:		

2. Are you currently being treated for any of the above injuries? ☐ No ☐ Yes Type of treatment:

3. Do you suffer from chronic pain? ☐ No ☐ Yes Where?
Back: ☐Neck ☐Upper ☐ Middle
☐ Lower ☐ Between shoulders blades
Other:

4. Are you sensitive to touch in any area? ☐ No ☐ Yes Where?

5. Do you have tension or soreness in a specific part of your body? ☐ No ☐ Yes Where?

6. Do you have numbness or stabbing pains anywhere? ☐ No ☐ Yes Where?

7. Are you currently under treatment for a medical condition? ☐ No ☐ Yes For what?

Injuries, Pain and General Health continued

8. If female, are you currently pregnant?	☐ No	☐ Yes	Due date:
9. Are you epileptic?	☐ No	☐ Yes	Controlled by medication? ☐ No ☐ Yes
10. Are you presently taking any medication?	☐ No	☐ Yes	Please list type and purpose.
11. Do you currently take any nutritional supplements?	☐ No	☐ Yes	Which ones?
12. Do you smoke cigarettes?	☐ No	☐ Yes	How many per day?
13. Have you ever quit smoking?	☐ No	☐ Yes	How long ago?
14. Has your doctor ever told you you have any of the following: ☐ High Blood Pressure ☐ High Cholesterol ☐ Diabetes ☐ Heart Disease	☐ No	☐ Yes	Last BP reading if known: _____ Last cholesterol measurement if known: Total _____ HDL _____ LDL _____

15. Is there anything in your medical history not previously referenced that you think is important to mention?

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