



H E A T
HIGH ENERGY ADVANCED TRAINING

NAME: _____

DOB: _____

ADDRESS: _____

PHONE: _____

• **TESTING DATE:** _____

- THE COST OF THE PROGRAM:

12 WEEKS	\$450	RUN/PLYO \$275
10 WEEKS	\$400	RUN/PLYO \$250
8 WEEKS	\$350	RUN/PLYO \$225
6 WEEKS	\$300	RUN/PLYO \$200
GIFT CERTIFICATE _____		WEEKS

- PAYMENT CAN BE MADE EITHER IN FULL OR HALF ON THE TESTING DATE. IF PAYING HALF, THE REMAINING BALANCE WILL BE DUE 3 WEEKS LATER, UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE.
- ACCEPTED PAYMENT METHODS ARE CASH, CHECK OR CREDIT CARD.

<input type="checkbox"/> MASTERCARD	<input type="checkbox"/> DISCOVER	<input type="checkbox"/> VISA
CARD NUMBER:	AMOUNT:	
SIGNATURE:	EXP. DATE	

Please list if any blood relative (parent, grandparent, aunt/uncle) has ever had any of the following. (Check all that apply)

Sudden death before the age of 50 _____

Cancer _____

Heart disease _____

High blood pressure _____

Stroke _____

Diabetes _____

Epilepsy _____

Blood diseases (sickle cell, anemia, leukemia) _____

Have you had or currently have any of the following? Please check and provide dates, if applicable.

- | | |
|-----------------------------------------------------|--------------------------------------------------------------|
| <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Scarlet fever |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Sickle cell anemia | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> High or Low Blood Pressure | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> Skin disorders | <input type="checkbox"/> Nervous stomach |
| <input type="checkbox"/> Migraine headaches | <input type="checkbox"/> Hernia |
| <input type="checkbox"/> Frequent skin infection | <input type="checkbox"/> Appendicitis |
| <input type="checkbox"/> Heat exhaustion | <input type="checkbox"/> Kidney/ bladder infection |
| <input type="checkbox"/> Heat stroke | <input type="checkbox"/> Frequent diarrhea |
| <input type="checkbox"/> Chronic sore throat | <input type="checkbox"/> Loss of an organ |
| <input type="checkbox"/> Congenital abnormality | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> HIV infection | <input type="checkbox"/> Concussion/fainting/unconsciousness |
| <input type="checkbox"/> Seizure disorder | <input type="checkbox"/> Stomach or intestinal problems |
| <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Other |

Please describe any past or current conditions you have experienced (muscle strains, sprains, fractures, surgery, back pain or any general discomfort)

Head/Neck

Shoulder/Clavicle

Arm/Elbow/Wrist/Hand

Back

Hip/Pelvis

Thigh/Knee

Lower leg/Ankle/Foot

Are there any other comments you would like to give concerning your health?

I do hereby state that to the best of my knowledge, I have given a correct and accurate medical history report.

Athlete's signature

Date

Parent or Guardian's signature

Date

PAR-Q

(A Questionnaire for People Aged 15 to 69)

YES	NO	
_____	_____	1. Has your doctor ever said that you have a heart condition <u>and</u> that you should only do physical activity recommended by a doctor?
_____	_____	2. Do you feel pain in your chest when you do physical activity?
_____	_____	3. In the past month, have you had chest pain when you were not doing physical activity?
_____	_____	4. Do you lose your balance because of dizziness or do you ever lose consciousness?
_____	_____	5. Do you have a bone or joint problem that could be made worse by a change in your physical activity?
_____	_____	6. Is your doctor currently prescribing drugs (for example, water pills) for your blood pressure or heart condition?
_____	_____	7. Do you know of any other reason why you should not do physical activity?

If you answered:

YES to one or more questions:

Talk with your doctor by phone or in person **BEFORE** you start becoming much more physically active or **BEFORE** you have a fitness appraisal. Tell your doctor about the PAR-Q and which questions you answered YES.

- You may be able to do any activity you want--as long as you start slow and build up gradually. Or, you may need to restrict your activities to those which are safe for you. Talk with your doctor about the kinds of activities you wish to participate in and follow his/her advice.
- Find out which community programs are safe and helpful for you.

NO to all questions:

If you answered **NO** honestly to all PAR-Q questions, you can be reasonably sure that you can:

- Start becoming much more physically active--begin slowly and build up gradually. This is the safest and easiest way to go.
- Take part in a fitness appraisal--this is an excellent way to determine your basic fitness so that you can plan the best way for you to live actively.

DELAY BECOMING MUCH MORE ACTIVE:

- If you are not feeling well because of temporary illness such as a cold or a fever--wait until you feel better; or
- If you are or may be pregnant--talk to your doctor before you start becoming active.

I have read, understood, and completed this questionnaire. Any questions I had were answered to my full satisfaction.

SIGNATURE _____

DATE _____

Referenced from ACSM's Guidelines for Exercise Testing and Prescription, Fifth Edition.

H.E.A.T.

HIGH ENERGY ADVANCED TRAINING

MISSION STATEMENT: It is a comprehensive approach to enhance or restore individual flexibility, strength, power, and speed as well as cardiovascular conditioning based on sound scientific and medical principles.

The following guidelines have been created to help you enjoy your experience with the H.E.A.T. program.

- The 6-week program must be completed within 7 weeks of original testing date. The 12-week program must be completed within 14 weeks of original testing date, unless other arrangements have been made with H.E.A.T. program director.
- H.E.A.T. participants may attend a maximum of 3 training sessions per week.
- H.E.A.T. participants must call to cancel appointment prior to scheduled session otherwise session is lost.
- All H.E.A.T. participants must check in at the front desk prior to workout.
- All participants are required to clean up after themselves, for example, return weights to racks, throw towels in appropriate bins, wipe down machines, etc...
- It is important that H.E.A.T. participants show mutual respect to other participants. Realize your words and actions may cause an unpleasant training session.

Thank you for your help.
H.E.A.T. staff

I agree with the following guidelines of the H.E.A.T. program

Signed _____ Date _____

H.E.A.T Introduction Sheet

Reasons for entering the H.E.A.T. program (sports, etc.)?

Goals that you would like to meet will in the H.E.A.T. program?

1) _____

2) _____

3) _____

How did you learn about the H.E.A.T. program?