

# PERSONAL TRAINING

## PERSONAL TRAINING

Your personal trainer will provide you with guidance, motivation, and the expertise you need to achieve your fitness goals. Get started today!

Appraisal	\$67.50
1 session	\$57.50
3 session	\$167.50
5 session	\$273.13
7 session	\$362.25
10 session	\$517.50

• All training sessions are 1 hour long.



### 1.5 Hour Personal Fitness Appraisal (Mandatory session)

The first 2 sessions you will meet with your fitness expert and they will assess your strength, flexibility, cardio and go over your fitness goals with you. In the second session, you will meet back with the trainer and they will go over the plan based off your assessment and goals.

### Personal Training

Our certified personal trainers will motivate and challenge you with focused, supervised workouts. Our trainers specialize in everything from overall conditioning and circuit training to high performance programs for various sports/activities.

For more information, contact 604.855.0500 or email [fitness@abbotsford.ca](mailto:fitness@abbotsford.ca)

### ABBOTSFORD RECREATION CENTRE

2499 McMillian Road | 604.853.4221

#### Facility Hours

Mon - Sun 5:30am - 10pm

#### Pool Hours

Mon - Sat 5:30am - 10pm  
Sun 10am - 10pm

**Holiday Hours** 10am - 6pm

### MATSQUI RECREATION CENTRE

3106 Clearbrook Road | 604.855.0500

#### Facility Hours

Mon - Sat 6am - 10pm  
Sun 10am - 8pm

#### Pool Hours

Mon - Sat 6am - 10pm  
Sun 10am - 8pm

**Holiday Hours** 10am - 6pm

**DIRECT2REC.COM**



# Fitness Questionnaire

Please complete the following questions. The more detailed the information, the better we can serve you! Come prepared to discuss your health and exercise history, lifestyle habits and current fitness and health goals.

NAME \_\_\_\_\_ EMAIL \_\_\_\_\_ PHONE \_\_\_\_\_

NEW CLIENT  YES  NO

PREFERRED CONTACT METHOD \_\_\_\_\_

ON A SCALE OF 1-10 (LOW TO HIGH), HOW WOULD YOU RATE YOUR CURRENT FITNESS LEVEL? \_\_\_\_\_

**FITNESS GOALS:** What are you trying to achieve? Check all that apply.

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> GENERAL OVERALL HEALTH    | <input type="checkbox"/> LIFESTYLE CHANGE           | <input type="checkbox"/> SPORT CONDITIONING  |
| <input type="checkbox"/> INCREASE MUSCLE STRENGTH  | <input type="checkbox"/> IMPROVE CARDIO ENDURANCE   | <input type="checkbox"/> POST-REHABILITATION |
| <input type="checkbox"/> IMPROVED BODY COMPOSITION | <input type="checkbox"/> IMPROVE EXERCISE TECHNIQUE | <input type="checkbox"/> OTHER               |

WHAT IS YOUR FITNESS ACTIVITY EXPERIENCE?

- BEGINNER  HIGH PERFORMANCE  RETURNING TO FITNESS  RECREATIONAL  OTHER

TRAINER PREFERENCE:

FEMALE  MALE NAME \_\_\_\_\_

AVAILABILITY:	MORNINGS 6AM - 12PM	AFTERNOONS 12PM - 5PM	EVENINGS 5PM - 10PM
WEEKDAYS			
WEEKENDS			

DO YOU HAVE ANY INJURIES OR MEDICAL CONDITIONS THAT AFFECT EXERCISE? IF SO, WHAT ARE THEY AND HOW LONG HAVE YOU HAD THEM?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Declaration: The City of Abbotsford assumes no liability for persons who undertake physical activity. If in doubt, consult your doctor prior to starting any physical activity. I acknowledge this physical activity clearance is valid for a maximum of 12 months from the date it is completed and becomes invalid if my condition changes. Personal training orientation cancellations require 24 hours notice in advance.

NAME \_\_\_\_\_ DATE OF BIRTH (YYYY/MM/DD) \_\_\_\_\_

SIGNATURE \_\_\_\_\_ WITNESS \_\_\_\_\_

IF UNDER THE AGE OF 16, PLEASE HAVE A PARENT/GUARDIAN COMPLETE THE FOLLOWING:

I HEREBY CONSENT FOR MY CHILD TO PARTICIPATE IN PHYSICAL ACTIVITY.  YES  NO

SIGNATURE \_\_\_\_\_ NAME PARENT/GUARDIAN \_\_\_\_\_

Personal information is collected for the administration of City of Abbotsford programs only, as authorized under Section 26 of the Freedom of Information and Protection of Privacy Act, the 'Act'. The City of Abbotsford does not use or disclose personal information for purposes other than those for which it is collected, except with the consent of the individual whom the information is about or otherwise in accordance with law. The City of Abbotsford retains personal information only as long as necessary for the purposes of the specified program and as required under the Act and other relevant legislation.

If you have any questions about the collection and use of your personal information, please contact the City of Abbotsford's Information & Privacy Coordinator by email at [foi@abbotsford.ca](mailto:foi@abbotsford.ca) or call 604-864-5575

<b>Fitness Administration Only</b>	Date Received _____
Assigned to Trainer _____	Date _____

## CITY OF ABBOTSFORD PERSONAL TRAINING CANCELLATION POLICY

Your appointments and well-being are very important to us. We understand that sometimes, unexpected delays can occur, making schedule adjustments.

Our goal is to provide quality health care to all our Clients in a timely manner. No-shows, late arrivals, and cancellations inconvenience not only our professionals, but our other clients as well. Please be aware of our policy regarding missed appointments.

### Appointment Cancellation

When you book your appointment, you are holding a space on our calendar that is no longer available to our other clients. In order to be respectful of your fellow patients, please reach out to your personal trainer as soon as you know you will not be able to make your appointment.

If cancellation is necessary, we require that you call at least 24 hours in advance. Appointments are in high demand, and your advanced notice will allow another client access to that appointment time.

### How to Cancel Your Appointment

If you need to cancel your appointment, please call your Personal Trainer as soon as possible, with a minimum of **24 hours in advance**. If necessary, you may leave a detailed voicemail message. We will confirm your cancellation has been received as soon as possible.

### Late Cancellations/No-Shows

A cancellation is considered late when the appointment is cancelled less than 24 hours' notice before the appointed time. A no-show is when a patient misses an appointment without cancelling. In either case, we will charge the client for the session.

For Appraisals missed, a no show or late cancellation will result in that session being removed, and you will only receive half of the appraisal.

I \_\_\_\_\_ (please print your name) understand the City of Abbotsford's Personal Training Cancellation Policy, and understand the City of Abbotsford has the right to charge me for any missed or late cancellations.

Client Signature \_\_\_\_\_

Personal Trainer Signature \_\_\_\_\_

Date: \_\_\_\_\_

# PAR-Q+






## The Physical Activity Readiness Questionnaire for Everyone

The health benefits of regular physical activity are clear; more people should engage in physical activity every day of the week. Participating in physical activity is very safe for MOST people. This questionnaire will tell you whether it is necessary for you to seek further advice from your doctor OR a qualified exercise professional before becoming more physically active.

### GENERAL HEALTH QUESTIONS

Please read the 7 questions below carefully and answer each one honestly: check YES or NO.	YES	NO
1) Has your doctor ever said that you have a heart condition <input type="checkbox"/> OR high blood pressure <input type="checkbox"/> ?	<input type="checkbox"/>	<input type="checkbox"/>
2) Do you feel pain in your chest at rest, during your daily activities of living, OR when you do physical activity?	<input type="checkbox"/>	<input type="checkbox"/>
3) Do you lose balance because of dizziness OR have you lost consciousness in the last 12 months? Please answer NO if your dizziness was associated with over-breathing (including during vigorous exercise).	<input type="checkbox"/>	<input type="checkbox"/>
4) Have you ever been diagnosed with another chronic medical condition (other than heart disease or high blood pressure)? PLEASE LIST CONDITION(S) HERE: _____	<input type="checkbox"/>	<input type="checkbox"/>
5) Are you currently taking prescribed medications for a chronic medical condition? PLEASE LIST CONDITION(S) AND MEDICATIONS HERE: _____	<input type="checkbox"/>	<input type="checkbox"/>
6) Do you currently have (or have had within the past 12 months) a bone, joint, or soft tissue (muscle, ligament, or tendon) problem that could be made worse by becoming more physically active? Please answer NO if you had a problem in the past, but it <b>does not limit your current ability</b> to be physically active. PLEASE LIST CONDITION(S) HERE: _____	<input type="checkbox"/>	<input type="checkbox"/>
7) Has your doctor ever said that you should only do medically supervised physical activity?	<input type="checkbox"/>	<input type="checkbox"/>

 **If you answered NO to all of the questions above, you are cleared for physical activity. Please sign the PARTICIPANT DECLARATION. You do not need to complete Pages 2 and 3.**

-  Start becoming much more physically active – start slowly and build up gradually.
-  Follow Global Physical Activity Guidelines for your age (<https://www.who.int/publications/i/item/9789240015128>).
-  You may take part in a health and fitness appraisal.
-  If you are over the age of 45 yr and NOT accustomed to regular vigorous to maximal effort exercise, consult a qualified exercise professional before engaging in this intensity of exercise.
-  If you have any further questions, contact a qualified exercise professional.

#### PARTICIPANT DECLARATION

If you are less than the legal age required for consent or require the assent of a care provider, your parent, guardian or care provider must also sign this form.

I, the undersigned, have read, understood to my full satisfaction and completed this questionnaire. I acknowledge that this physical activity clearance is valid for a maximum of 12 months from the date it is completed and becomes invalid if my condition changes. I also acknowledge that the community/fitness center may retain a copy of this form for its records. In these instances, it will maintain the confidentiality of the same, complying with applicable law.




NAME \_\_\_\_\_ DATE \_\_\_\_\_

SIGNATURE \_\_\_\_\_ WITNESS \_\_\_\_\_

SIGNATURE OF PARENT/GUARDIAN/CARE PROVIDER \_\_\_\_\_

 **If you answered YES to one or more of the questions above, COMPLETE PAGES 2 AND 3.**

#### Delay becoming more active if:

-  You are currently experiencing a temporary illness, such as a cold or fever. It is best to wait until you feel better.
-  You are pregnant. In this case, talk with your health care practitioner, physician, qualified exercise professional, and/or complete the ePARmed-X+ at [www.eparmedx.com](http://www.eparmedx.com) before becoming more physically active.
-  Your health changes. Answer the questions on Pages 2 and 3 of this document and/or talk to your health care practitioner, physician, or qualified exercise professional before proceeding with any physical activity program.

# PAR-Q+

## FOLLOW-UP QUESTIONS ABOUT YOUR MEDICAL CONDITION(S)

### 1. Do you have Arthritis, Osteoporosis, or Back Problems?

If the above condition(s) is/are present, answer questions 1a-1c If **NO**  go to question 2

- 1a. Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer **NO** if you are not currently taking medications or other treatments) YES  NO
- 1b. Do you have joint problems causing pain, a recent fracture or fracture caused by osteoporosis or cancer, displaced vertebra (e.g., spondylolisthesis), and/or spondylolysis/pars defect (a crack in the bony ring on the back of the spinal column)? YES  NO
- 1c. Have you had steroid injections or taken steroid tablets regularly for more than 3 months? YES  NO

### 2. Do you currently have Cancer of any kind?

If the above condition(s) is/are present, answer questions 2a-2b If **NO**  go to question 3

- 2a. Does your cancer diagnosis include any of the following types: lung/bronchogenic, multiple myeloma (cancer of plasma cells), head, and/or neck? YES  NO
- 2b. Are you currently receiving cancer therapy (such as chemotherapy or radiotherapy)? YES  NO

### 3. Do you have a Heart or Cardiovascular Condition? This includes Coronary Artery Disease, Heart Failure, Diagnosed Abnormality of Heart Rhythm

If the above condition(s) is/are present, answer questions 3a-3d If **NO**  go to question 4

- 3a. Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer **NO** if you are not currently taking medications or other treatments) YES  NO
- 3b. Do you have an irregular heart beat that requires medical management? (e.g., atrial fibrillation, premature ventricular contraction) YES  NO
- 3c. Do you have chronic heart failure? YES  NO
- 3d. Do you have diagnosed coronary artery (cardiovascular) disease and have not participated in regular physical activity in the last 2 months? YES  NO

### 4. Do you currently have High Blood Pressure?

If the above condition(s) is/are present, answer questions 4a-4b If **NO**  go to question 5

- 4a. Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer **NO** if you are not currently taking medications or other treatments) YES  NO
- 4b. Do you have a resting blood pressure equal to or greater than 160/90 mmHg with or without medication? (Answer **YES** if you do not know your resting blood pressure) YES  NO

### 5. Do you have any Metabolic Conditions? This includes Type 1 Diabetes, Type 2 Diabetes, Pre-Diabetes

If the above condition(s) is/are present, answer questions 5a-5e If **NO**  go to question 6

- 5a. Do you often have difficulty controlling your blood sugar levels with foods, medications, or other physician-prescribed therapies? YES  NO
- 5b. Do you often suffer from signs and symptoms of low blood sugar (hypoglycemia) following exercise and/or during activities of daily living? Signs of hypoglycemia may include shakiness, nervousness, unusual irritability, abnormal sweating, dizziness or light-headedness, mental confusion, difficulty speaking, weakness, or sleepiness. YES  NO
- 5c. Do you have any signs or symptoms of diabetes complications such as heart or vascular disease and/or complications affecting your eyes, kidneys, **OR** the sensation in your toes and feet? YES  NO
- 5d. Do you have other metabolic conditions (such as current pregnancy-related diabetes, chronic kidney disease, or liver problems)? YES  NO
- 5e. Are you planning to engage in what for you is unusually high (or vigorous) intensity exercise in the near future? YES  NO

# PAR-Q+

**6. Do you have any Mental Health Problems or Learning Difficulties?** This includes Alzheimer's, Dementia, Depression, Anxiety Disorder, Eating Disorder, Psychotic Disorder, Intellectual Disability, Down Syndrome

If the above condition(s) is/are present, answer questions 6a-6b

If **NO**  go to question 7

6a. Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer **NO** if you are not currently taking medications or other treatments) YES  NO

6b. Do you have Down Syndrome **AND** back problems affecting nerves or muscles? YES  NO

**7. Do you have a Respiratory Disease?** This includes Chronic Obstructive Pulmonary Disease, Asthma, Pulmonary High Blood Pressure

If the above condition(s) is/are present, answer questions 7a-7d

If **NO**  go to question 8

7a. Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer **NO** if you are not currently taking medications or other treatments) YES  NO

7b. Has your doctor ever said your blood oxygen level is low at rest or during exercise and/or that you require supplemental oxygen therapy? YES  NO

7c. If asthmatic, do you currently have symptoms of chest tightness, wheezing, laboured breathing, consistent cough (more than 2 days/week), or have you used your rescue medication more than twice in the last week? YES  NO

7d. Has your doctor ever said you have high blood pressure in the blood vessels of your lungs? YES  NO

**8. Do you have a Spinal Cord Injury?** This includes Tetraplegia and Paraplegia

If the above condition(s) is/are present, answer questions 8a-8c

If **NO**  go to question 9

8a. Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer **NO** if you are not currently taking medications or other treatments) YES  NO

8b. Do you commonly exhibit low resting blood pressure significant enough to cause dizziness, light-headedness, and/or fainting? YES  NO

8c. Has your physician indicated that you exhibit sudden bouts of high blood pressure (known as Autonomic Dysreflexia)? YES  NO

**9. Have you had a Stroke?** This includes Transient Ischemic Attack (TIA) or Cerebrovascular Event

If the above condition(s) is/are present, answer questions 9a-9c

If **NO**  go to question 10

9a. Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer **NO** if you are not currently taking medications or other treatments) YES  NO

9b. Do you have any impairment in walking or mobility? YES  NO

9c. Have you experienced a stroke or impairment in nerves or muscles in the past 6 months? YES  NO

**10. Do you have any other medical condition not listed above or do you have two or more medical conditions?**

If you have other medical conditions, answer questions 10a-10c

If **NO**  read the Page 4 recommendations

10a. Have you experienced a blackout, fainted, or lost consciousness as a result of a head injury within the last 12 months **OR** have you had a diagnosed concussion within the last 12 months? YES  NO

10b. Do you have a medical condition that is not listed (such as epilepsy, neurological conditions, kidney problems)? YES  NO





10c. Do you currently live with two or more medical conditions? YES  NO

**PLEASE LIST YOUR MEDICAL CONDITION(S)  
AND ANY RELATED MEDICATIONS HERE:**

**GO to Page 4 for recommendations about your current medical condition(s) and sign the PARTICIPANT DECLARATION.**

# PAR-Q+




 **If you answered NO to all of the FOLLOW-UP questions (pgs. 2-3) about your medical condition, you are ready to become more physically active - sign the PARTICIPANT DECLARATION below:**

-  It is advised that you consult a qualified exercise professional to help you develop a safe and effective physical activity plan to meet your health needs.
-  You are encouraged to start slowly and build up gradually - 20 to 60 minutes of low to moderate intensity exercise, 3-5 days per week including aerobic and muscle strengthening exercises.
-  As you progress, you should aim to accumulate 150 minutes or more of moderate intensity physical activity per week.
-  If you are over the age of 45 yr and **NOT** accustomed to regular vigorous to maximal effort exercise, consult a qualified exercise professional before engaging in this intensity of exercise.

 **If you answered YES to one or more of the follow-up questions about your medical condition:**

You should seek further information before becoming more physically active or engaging in a fitness appraisal. You should complete the specially designed online screening and exercise recommendations program - the **ePARmed-X+** at [www.eparmedx.com](http://www.eparmedx.com) and/or visit a qualified exercise professional to work through the ePARmed-X+ and for further information.

 **Delay becoming more active if:**

-  You are currently experiencing a temporary illness, such as a cold or fever. It is best to wait until you feel better.
-  You are pregnant. In this case, talk to your health care practitioner, physician, qualified exercise professional, and/or complete the ePARmed-X+ at [www.eparmedx.com](http://www.eparmedx.com) before becoming more physically active.
-  Your health changes. Talk to your health care practitioner, physician, or qualified exercise professional before continuing with any physical activity program.

- You are encouraged to photocopy the PAR-Q+. You must use the entire questionnaire and NO changes are permitted.
- The authors, the PAR-Q+ Collaboration, partner organizations, and their agents assume no liability for persons who undertake physical activity and/or make use of the PAR-Q+ or ePARmed-X+. If in doubt after completing the questionnaire, consult your doctor prior to physical activity.

## PARTICIPANT DECLARATION

- All persons who have completed the PAR-Q+ please read and sign the declaration below.
- If you are less than the legal age required for consent or require the assent of a care provider, your parent, guardian or care provider must also sign this form.

*I, the undersigned, have read, understood to my full satisfaction and completed this questionnaire. I acknowledge that this physical activity clearance is valid for a maximum of 12 months from the date it is completed and becomes invalid if my condition changes. I also acknowledge that the community/fitness center may retain a copy of this form for records. In these instances, it will maintain the confidentiality of the same, complying with applicable law.*

NAME \_\_\_\_\_

DATE \_\_\_\_\_

SIGNATURE \_\_\_\_\_

WITNESS \_\_\_\_\_

SIGNATURE OF PARENT/GUARDIAN/CARE PROVIDER \_\_\_\_\_

**For more information, please contact**

**[www.eparmedx.com](http://www.eparmedx.com)  
Email: [eparmedx@gmail.com](mailto:eparmedx@gmail.com)**

### Citation for PAR-Q+

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### Key References

1. Jamnik VK, Warburton DER, Makarski J, McKenzie DC, Shephard RJ, Stone J, and Gledhill N. Enhancing the effectiveness of clearance for physical activity participation; background and overall process. APNM 36(S1):S3-S13, 2011.
2. Warburton DER, Gledhill N, Jamnik VK, Bredin SSD, McKenzie DC, Stone J, Charlesworth S, and Shephard RJ. Evidence-based risk assessment and recommendations for physical activity clearance; Consensus Document. APNM 36(S1):S266-S298, 2011.
3. Chisholm DM, Collis ML, Kulak LL, Davenport W, and Gruber N. Physical activity readiness. British Columbia Medical Journal. 1975;17:375-378.
4. Thomas S, Reading J, and Shephard RJ. Revision of the Physical Activity Readiness Questionnaire (PAR-Q). Canadian Journal of Sport Science 1992;17:4 338-345.

The PAR-Q+ was created using the evidence-based AGREE process (1) by the PAR-Q+ Collaboration chaired by Dr. Darren E. R. Warburton with Dr. Norman Gledhill, Dr. Veronica Jamnik, and Dr. Donald C. McKenzie (2). Production of this document has been made possible through financial contributions from the Public Health Agency of Canada and the BC Ministry of Health Services. The views expressed herein do not necessarily represent the views of the Public Health Agency of Canada or the BC Ministry of Health Services.