

PERSONAL TRAINING

recreation
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ABBOTSFORD

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	\$70
1 session	\$59.50
3 session	\$174
5 session	\$283
7 session	\$375
10 session	\$536

- 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

ABBOTSFORD RECREATION CENTRE

2499 McMillan 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.

- | | | |
|--|---|--|
| ☐ GENERAL OVERALL HEALTH | ☐ LIFESTYLE CHANGE | ☐ SPORT CONDITIONING |
| ☐ INCREASE MUSCLE STRENGTH | ☐ IMPROVE CARDIO ENDURANCE | ☐ POST-REHABILITATION |
| ☐ IMPROVED BODY COMPOSITION | ☐ IMPROVE EXERCISE TECHNIQUE | ☐ 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	M	T	W	Th	F			
WEEKENDS	Sa	Su						

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 _____

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 or call 604-864-5575

Fitness Administration Only

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 _____

Fitness Administration Only

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 ☐ OR high blood pressure ☐ ?	☐	☐
2) Do you feel pain in your chest at rest, during your daily activities of living, OR when you do physical activity?	☐	☐
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).	☐	☐
4) Have you ever been diagnosed with another chronic medical condition (other than heart disease or high blood pressure)? PLEASE LIST CONDITION(S) HERE: _____	☐	☐
5) Are you currently taking prescribed medications for a chronic medical condition? PLEASE LIST CONDITION(S) AND MEDICATIONS HERE: _____	☐	☐
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 does not limit your current ability to be physically active. PLEASE LIST CONDITION(S) HERE: _____	☐	☐
7) Has your doctor ever said that you should only do medically supervised physical activity?	☐	☐



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 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** 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 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
Email: eparmedx@gmail.com**

Citation for PAR-Q+

Warburton DER, Jamnik VK, Bredin SSD, and Gledhill N on behalf of the PAR-Q+ Collaboration. The Physical Activity Readiness Questionnaire for Everyone (PAR-Q+) and Electronic Physical Activity Readiness Medical Examination (ePARmed-X+). Health & Fitness Journal of Canada 4(2):3-23, 2011.

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.

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