FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

Y WEIGHT LOSS CHALLENGE

Spring 2016

Be our next "before" and "after" in this 12-week program. Average weight loss per person is approximately 20 pounds! When you join this friendly competition, you'll lose weight with your team and get fit by exercising with a personal trainer three times a week for 12 weeks. They will assist you to develop realistic goals, make healthy lifestyle changes and use weight management techniques to improve your overall health and wellness.

Fee: 3x per week for 12 weeks: YMCA Members $360, Non-Members $720

Payment will be due at kickoff meeting. Monthly installment option (three months) is available.

April 4, 2016 — **Application Packet Due**
Packet consists of 3 items: Application, Medical Questionnaire, Physician's Clearance (please place all in a sealed envelope marked Attn: Y Weight Challenge) and provide to the service center.

April 6 – April 10, 2016 — **Team Kick-off Meetings at Four Rivers Family YMCA**
Meet your personal trainer and teammates, review rules of competition, get measured, weighed and before photo taken. No workout. Wear comfortable clothing. Trainers will schedule team specific meetings.

April 11, 2016 — **Program Begins**
This will be the first week of the 12-week program; participants will meet with the team and with Personal Trainer 3 times per week.

July 1, 2016 — **Program Ends**
Final weigh in and circumference measurements taken this week.

Name_____ Birth Date_____

Address_____

Phone _____ E-mail _____

Cell_____

Y Member: Yes No Weight: _____ Height: _____ Gender: Male Female

Doctor Name/Phone_____

Emergency Contact / Phone_____

Days and Times Preferred: _____

Please provide the days and times you can meet with your team and personal trainer for weekly workouts. Be flexible! You must meet with your team for your workouts three times a week. For workout times, please indicate a range of times, time period, not just one specific time. Also indicate morning, afternoon or evening with your time range. Your team personal trainer will have the final say on when the workouts take place. If your schedule does not permit you to work in any of the days and times of any of the teams, you cannot participate in the program.

Photo/News/Testimonial Release

I grant the Gateway Region YMCA, its agents and news media the right to photograph, record and/or interview me and/or my family and to use for news, publicity and marketing purposes. I warrant that the rights granted herein do not conflict with any existing commitments on my part.
Signature (optional)_____Date: _____

Physician's Release Form

Date:_____

Dear Physician,

Your patient, _____ wishes participate/continue in a personalized exercise program with the Four Rivers Family YMCA Personal Training Department. As a participant in this program, your patient will be instructed in proper exercise techniques working with a Nationally Certified Personal Trainer.

All of our personal trainers will follow the American College of Sports Medicine (ACSM) guidelines for exercise testing and prescription. Their guidelines in short will be as follows. If you wish to see a specific workout for your patient please contact the office.

	Cardiovascular Fitness	Muscular Fitness
Frequency	3-5 days/week	At least 2 days/week
Intensity	60-75% Max Heart Rate	Moderate Resistance
Duration	20-60 minutes	Approximately one hour
Mode of Activity	Aerobic exercise	Strength training major muscle groups

Are there any medical factors in your patient's history, or any medications that are currently being taken which would affect exercise programming or the patient's ability to participate in a non-medically supervised exercise program? Please Circle: **Yes** **No**

If yes, please explain:

_____
_____
_____

Please identify any recommendations or restrictions that are appropriate for your patient in this exercise program:

_____
_____
_____

My patient, _____has my approval to begin/continue an exercise program with the Four Rivers Family YMCA Personal Training Department with the recommendations or restrictions stated above.

_____ _____

Physicians name/phone number ***Physician's Signature***

Thank You,

Michelle Villmer
Physical Director
Four Rivers Family YMCA
400 Grand Avenue
Washington, MO 63090
(636) 239-5704
michelle.villmer@gwrymca.org

Medical/Health Status Questionnaire

Participant to Complete

Please answer every question as accurately as possible so that a correct assessment can be made. Please place a "Y" in the space to the left of the question to answer "yes." Leave blank if your answer is "no." Please ask if you have any questions. Your responses will be treated in a confidential manner.

Your name: _____ Date: _____

Medical Screening Questionnaire – Please indicate yes or no

___ Do you have any personal history of heart disease?
___ Any personal history of metabolic disease (thyroid, renal, liver)?
___ Have you had diabetes for less than 15 years?
___ Have you had diabetes for 15 years or more?
___ Pain or discomfort in your chest apparently due to blood flow deficiency?
___ Any unaccustomed shortness of breath (perhaps during light exercise)?
___ Have you had any problems with dizziness or fainting?
___ Difficulty breathing while standing or sudden breathing problems at night?
___ Do you suffer from ankle edema (swelling of the ankles)?
___ Have you experienced a rapid throbbing or fluttering of the heart?
___ Have you experienced severe pain in leg muscles during walking?
___ Do you have a known heart murmur?
___ Any family history of cardiac or pulmonary disease prior to age 55?
___ Have you been assessed as hypertensive on at least 2 occasions?
___ Has your serum cholesterol been measured at greater than 240 mg/dl?
___ Would you characterize your lifestyle as "sedentary"?

Medical History

___ Are you currently being treated for high blood pressure? If you know your average blood pressure, please enter: _____

Please Check All That Apply:

___ Has a doctor ever found an abnormal EKG?
___ Abnormal Chest X-Ray?
___ Swollen or Painful Joints?
___ Asthma?
___ Bronchitis?
___ Recently Broken Bones?
___ Epilepsy or seizures?
___ Persistent Fatigue?
___ Anemia?
___Limited Range of Motion?
___ Bursitis?
___ Low Blood Pressure?
___ Knee Problems?
___ Shoulder Problems?
___ Other Lung Problems?
___ Chronic/Migraine
___ Stomach Problems?
___ Are You Pregnant?
___ Rheumatic Fever?
___ Foot Problems?
___ Arthritis?
___ Emphysema?
___ Stroke?
___ Headaches?
___ Hernia?
___ Has a doctor imposed and activity restrictions? If so, please describe:

_____

Family History

Has your mother, father, or siblings suffered from (please select all that apply):

___ Congenital heart disease or left ventricular hypertrophy.
___ Heart attack or surgery prior to age 55 ___ Stroke prior to age 50
___ High cholesterol ___ Diabetes
___ Obesity ___ Hypertension
___ Osteoporosis ___ Asthma
___ Leukemia or cancer prior to age 60

Current Medications
___ Diuretics Other Cardiovascular
___ Beta Blockers
___ NSAIDS/ Anti-Inflammatories (Motrin, Advil)
___ Vasodilators
___ Cholesterol
___ Alpha Blockers
___ Diabetes/Insulin
___Calcium Channel Blockers
Other specific medications that you currently take: _____

Activities and Goals
On average, how many times do you exercise per week? _____
On average, how long do you exercise? _____
On a scale from 1 to 10, how intense is your typical workout?
Very Easy 1 2 3 4 5 6 7 8 9 10 Very Intense

For each activity that you participate in, indicate your typical exercise time in minutes:
Running/Jogging:___ Weight Training:___ Skiing/Boarding:___
Walking:___ Aerobics Classes:___ Yoga/Martial Arts:___
Stair Climbing:___ Swimming:___ Other:_____
Bicycle/Spinning:___ Racquet Sports:___

Lifestyle
Current cigarette smoker? ___ If so, how many per day: ___
Previous cigarette smoker? ___ If so, when did you quit? ___
How many years have you smoked or did you smoke before quitting? ___
Do you/did you smoke: cigarettes? cigars? pipe?
Please Rate Your Daily Stress Levels (select one):
Low Moderate High: I enjoy the challenge High: sometimes difficult to handle
High: often difficult to handle
Alcoholic Beverages? ___ Consumption on a scale of 1 to 10?_____
1 = 1 glass of wine 10 = 1 liter bottle of wine _____

Dietary Habits. Please Select All That Apply
___ I seldom consume red or high fat meats
___ I pursue a low-fat diet
___ I eat at least 5 servings of fruits/vegetables per day
___ I almost always eat a full, healthy breakfast
___ My diet includes many high-fiber foods
___ I rarely eat sugar or high-fat desserts

Any Other Medical Conditions or Activity Restrictions
Please be as accurate and complete as possible.
_____
_____
Any other information critical to understanding your readiness for exercise?
_____
_____

Thank you.