the YMCA
FOR YOUTH DEVELOPMENT
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

Y WEIGHT LOSS CHALLENGE
2016

Be our next "before" and "after" in this 8-week program. Average weight loss per person in this program is 1-2 pounds a week! When you join this friendly competition, you'll lose weight with your team and get fit by exercising with a personal trainer up to three times a week for 8 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. **If you miss a class, instructions will be given by your trainer on making up sessions missed.**

3x per week for **8 weeks**
YMCA Members = $240
Non-Members = $480

Payment will be due by first meeting. Monthly payments options are available.

By July 8, 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.*
July 11, 2016	**Program Begins** *This will be the first week of the 8-week program; participants will meet with the team and with Personal Trainer 2-3 times per week.*
September 2, 2016	**Program Ends** *Final weigh in and circumference measurements taken that week.*

Name: _____

MEMBER INFORMATION:

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 YMCA of Greater St. Louis, 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 O'Fallon Family YMCA Personal Training Department. As a participant in this program, your patient will be instructed in proper exercise techniques working one on one 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 O'Fallon Family YMCA Personal Training Department with the recommendations or restrictions stated above.

_____
Physicians name/phone number

_____
Physician's Signature

Thank You,

Connor P. Brown
Health and Wellness Director
YMCA O'Fallon
Connor.brown@gwrymca.org
636-379-0092

TRAINING TIMES:
Highlight the session you would like to attend.

Kristi Bradley-
Monday, Wednesday, Friday.
9:00am- 10:00am

Willie Ocampo-
Tuesday and Thursday
6:00pm- 7:00pm

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?
___ Rheumatic Fever?
___ Swollen or Painful Joints?
___ Asthma?
___ Arthritis?
___ Bronchitis?
___ Recently Broken Bones?
___ Stroke?
___ Epilepsy or seizures?
___ Headaches?
___ Persistent Fatigue?
___ Anemia?
___ Limited Range of Motion?
___ Bursitis?
___ Foot Problems?
___ Low Blood Pressure?
___ Knee Problems?
___ Emphysema?
___ Shoulder Problems?
___ Other Lung Problems?
___ Hernia?
___ Chronic/Migraine
___ Hernia?
___ Stomach Problems?
___ Are You Pregnant?
___ 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?
_____
_____