

EXPIRED FITNESS LEADER ICE PACKAGE

CANDIDATE INFORMATION: Please print clearly.

First Name	Last Name	BCRPA Leader ID
Current Email Address in the Registry®		
Current First Aid & CPR in The Registry®	Attached	Yes No In The Registry® Yes No

STEP 1: Pre-requisites

Before completing this ICE package, please ensure the following:

- You are currently fully registered as a BCRPA Weight Training Leader.
- You have a current CPR certificate (minimum CPR-A) and a current First Aid certificate (minimum Emergency First Aid).

Step 2: PERSONAL TRAINING INSTRUCTOR COMPETENCY EVALUATION (ICE) PROCEDURE:

1. Before contacting an Evaluator:

- Use Form E Phase 1 and 2 to design your personal training program from the scenarios found in the Appendix 1 Case Studies.
- Be prepared to demonstrate the tests described in Form F Parts 1 and 3 during the evaluation.
- Be prepared to demonstrate the practical components in Form G.
- Obtain permission from a fitness facility to use it for the evaluation, and arrange for a friend to act as “clients” during the evaluation

2. Contact an Evaluator:

The list of Evaluators can be found here: [PERSONAL TRAINING EVALUATORS](#) The evaluator will discuss the ICE procedure. The evaluator will also discuss the date, time and location of the ICE as well as any fees they may charge you to conduct the ICE.

INSTRUCTOR COMPETENCY EVALUATION (ICE)

ICE can be done virtually. Video ICEs are also accepted. Arrangements should be confirmed directly with the ICE evaluator.

Your evaluator will email BCRPA a confirmation once you have completed and passed the ICE.

PLEASE ALLOW 5 - 10 BUSINESS DAYS FOR PROCESSING upon receiving confirmation from ICE evaluator. Check The Registry® of Fitness Professionals for registration status in the specialty. BCRPA will not notify Fitness Leaders regarding the status of the ICE package.

Date of ICE:



BCRPA Personal Training ICE ICE Program Design Card

Form E-Phase 1

PHASE I: Current Program				Education:										
Name:														
Age:														
Gender:														
		Warm Up:			Cardio:			Cooldown:			Weights:			
F – Frequency														
I – Intensity														
T – Time														
T – Type														
Need to See														
	Resistance Exercises	Set	Day 1			Day 2			Day 3			Day 4		
			1	2	3	1	2	3	1	2	3	1	2	3
1		Wt.												
		Reps												
2		Wt.												
		Reps												
3		Wt.												
		Reps												
4		Wt.												
		Reps												
5		Wt.												
		Reps												
6		Wt.												
		Reps												
7		Wt.												
		Reps												
8		Wt.												
		Reps												
9		Wt.												
		Reps												

Form E-Phase 1

	Flexibility:	Core:	Comments:
F – Frequency			
I – Intensity			
T – Time			
T – Type			
Need to See			
	Muscle	Stretch	
1			
2			
3			
4			
5			
6			
7			
8			

Evaluator Use only	
Max 5 points per category: Frequency – 1 point Intensity – 1 point Type – 1 point Time – 1 point Demonstrates “Need to See” – 1 point	
Education:	/5
Red Flags:	/5
Exercise Selection:	/5
Warm Up:	/5
Cardio:	/5
Cooldown:	/5
Weights:	/5
Flexibility:	/5
Core:	/5
Total Phase 1:	/45

Identify Red Flags in Program Design: _____



**BCRPA Personal Training ICE
ICE Program Design Card**

Form E-Phase 2

PHASE I: Current Program				Education:										
Name:														
Age:														
Gender:														
		Warm Up:			Cardio:			Cooldown:			Weights:			
F – Frequency														
I – Intensity														
T – Time														
T – Type														
Need to See														
	Resistance Exercises		Day 1			Day 2			Day 3			Day 4		
		Set	1	2	3	1	2	3	1	2	3	1	2	3
1		Wt.												
		Reps												
2		Wt.												
		Reps												
3		Wt.												
		Reps												
4		Wt.												
		Reps												
5		Wt.												
		Reps												
6		Wt.												
		Reps												
7		Wt.												
		Reps												
8		Wt.												
		Reps												
9		Wt.												
		Reps												

Form E-Phase 2

	Flexibility:	Core:	Comments:
F – Frequency			
I – Intensity			
T – Time			
T – Type			
Need to See			
	Muscle	Stretch	
1			
2			
3			
4			
5			
6			
7			
8			

Evaluator Use only	
Max 5 points per category: Frequency – 1 point Intensity – 1 point Type – 1 point Time – 1 point Demonstrates “Need to See” – 1 point	
Education:	/5
Red Flags:	/5
Exercise Selection:	/5
Warm Up:	/5
Cardio:	/5
Cooldown:	/5
Weights:	/5
Flexibility:	/5
Core:	/5
Total Phase 2:	/45

Identify Red Flags in Program Design: _____

F1. HAMSTRING FLEXIBILITY TESTING – HIP FLEXION

Purpose: To evaluate range of motion in the hips and hamstring tightness. Limitations to hip flexion place undue stress on the low back, increasing risk for low-back pain and injury.

Candidate to demonstrate the following (Maximum 3 points):

Total F1: ___/3

<p>F3: GIRTH MEASUREMENTS</p> <p>Candidate to choose one of the following sites:</p> <ol style="list-style-type: none"> 1. Upper Arm 2. Waist 3. Hips 4. Mid-thigh 	<p>Candidate must demonstrate:</p> <ol style="list-style-type: none"> 1. Knowledge of landmark 2. Protocol-asking permission 3. Practical Technique-skills <p>Candidate to explain the limitations associated with the use of this testing (1 Point)</p>
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Girth Measurement Site:

1. Knowledge of landmark
2. Protocol - asking permission
3. Practical technique - skills

Subtotal (3 points Maximum) ___/3

Limitations associated with the use of this testing (1 Point):

Score (max. 1 point):

Total F3: ___/4

DEMONSTRATE TEACHING SKILLS:

Exercise/Stretches: Candidate to demonstrate 3 exercises and stretches (1 Upper Body, 1 Lower Body and 1 Core) from the Program Design. Exercises will be rated on the following criteria:

1. Adjust Equipment/Workload/Body Position: Adjusts seat height/lever lengths to oppose the line of resistance. Determines the workload.
2. Consistent ROM through all repetitions.
3. Stabilization: Ensures that joints not involved in the exercise, especially those above and below involved joints, are stabilized. Body position is checked.
4. Movement Speed: Teaches appropriate speed of execution for a single repetition, exceptions may be appropriate for static stretches.
5. Breathing: Avoids holding breath. Ensures inhalation and exhalation during each repetition is appropriate for the exercise and velocity.
6. Musculoskeletal Knowledge: Describes muscle(s)/muscle group(s) and joints involved in the exercise.
7. Points of Concern: Educates participant on common technique errors for the exercise. Describes how to correct them.
8. Spotting: Demonstrates proper spotting techniques in order to minimize the risk of injury during the execution of the exercise.
9. Modification: Offers alternative exercises. Indicates for whom this exercise would be high risk.
10. Teaching Skills: Uses appropriate teaching skills for each exercise. (Description below.)

Teaching Skills: Practical Demonstration of Warm-Up and Weight Room Exercises

1. Body Language/Kinesthetic: Awareness of position that is appropriate for best instruction. Makes eye contact. Observes participant's technique/response. Uses hands touch appropriately. Demonstrates good posture, hygiene, and attire.
2. Voice: Tone, volume, tempo, inflection and projection appropriate for surroundings and participant.
3. Education/Explanation: Uses clear, complete instructions. Uses correct anatomical terminology, plus general terms. Questions participant for feedback and adjusts exercise accordingly.
4. Concise: Avoids information overload. Uses a step-by-step approach. Integrates education and instruction into exercise activity times. Instruction of each exercise, with 8-15 repetitions, takes approximately two minutes.

.5 point per criteria	Exercise Upper Body	Stretch Upper Body	Exercise Lower Body	Stretch Lower Body	Exercise Core	Stretch Core
Adjust Equipment/Workload/Body Position:						
ROM						
Stabilization						
Movement						
Breathing						
Musculoskeletal Knowledge						
Points of Concern						
Spotting						
Modification						
Teaching Skills						
Total (5 Points per exercise/Stretch)	/5	/5	/5	/5	/5	/5

Total Form G: ____/30



BCRPA Personal Training ICE Scoring Form

Form H

ICE PASS STANDARDS:

Passing Mark = 75% in EACH area. Participants who fail in one area may redo the area of deficiency with the same evaluator (fees may apply). This re-assessment must be noted on the same form.

Form	Maximum Mark	Score	Percent
E	90		%
F	6		%
G	30		%
Total	126		%

Pass

Yes

No

Evaluator Name:	ICE Candidate Name:
Evaluator Phone Number:	ICE Candidate Phone Number:
Evaluator Signature:	ICE Candidate Signature:
Date:	Date:

Case Study #1 - Michelle

CASE STUDY #1 – SCENARIO:

Michelle is a 28-year old pregnant female. She has been exercising two to three times per week for the last six months. She has just found out she is 6 weeks pregnant with her first child. Michelle is available to workout 2-3 times per week for one hour each time. She is a part time teaching assistant at an elementary school.

Phase I Situation

Her Goals	<input type="checkbox"/> Wants to maintain a reasonable level of fitness during pregnancy. She heard it helps with delivery. <input type="checkbox"/> Does not want excessive weight gain during pregnancy <input type="checkbox"/> Wants to maintain her energy levels during pregnancy <input type="checkbox"/> Does not want to endanger baby due to exercise
Height	5 ft. 5 in.
Weight	145 lbs.
Resting BP	128/82 mmHG
Resting HR	72 bpm
Blood Lipids	Normal
Medication	None
Max METS	Will change due to pregnancy
Availability	See intro
Activities	<input type="checkbox"/> Occasionally walks with husband <input type="checkbox"/> Plays recreation softball 1x/week during summer
Injuries	None; lower back occasionally aches
Medical Diagnosis & Prescription	Pregnant; Physician clearance to exercise
Lifestyle	<input type="checkbox"/> Sometimes misses breakfast <input type="checkbox"/> Sleeps 7-8 hrs/night <input type="checkbox"/> Semi-active 9am-3pm job

Phase II Situation

Baby has arrived 8 months ago and she would like a new program to help her get back in shape

CASE STUDY #1 – HEALTH SCREENING QUESTIONNAIRE:

Taking part in any activity or exercise program can be an excellent way to improve or maintain your health and fitness levels, but preparation is required to enable a safe and effective program. Please answer the following questions to assess your own physical readiness:

		Yes	No
1.	Do you have any health or medical concerns? If yes, please specify 6 weeks pregnant	X	
2.	Are you currently taking any medication? If yes, list medications and for what condition Medication _____ Condition _____ Medication _____ Condition _____		X
3.	Do you smoke? If yes, how much? _____		X
4.	Do you, or have you ever had, any of the following health conditions?		
	<input type="checkbox"/> Blood Pressure Concerns:		X
	<input type="checkbox"/> Heart Murmur:		X
	<input type="checkbox"/> Any heart trouble:		X
	<input type="checkbox"/> Chest pains/pressure:		X
	<input type="checkbox"/> Disease of arteries:		X
	<input type="checkbox"/> Asthma/allergies:		X
	<input type="checkbox"/> High Cholesterol:		X
	<input type="checkbox"/> Back injury		X
	<input type="checkbox"/> Back pains:	X	
	<input type="checkbox"/> Epilepsy:		X
	<input type="checkbox"/> Diabetes:		X
	<input type="checkbox"/> Varicose veins:		X
	<input type="checkbox"/> Lung Disease:		X
	<input type="checkbox"/> Dizziness/Fainting spells:		X
	<input type="checkbox"/> Arthritis:		X
	<input type="checkbox"/> Osteoporosis:		X
5.	Have you ever injured or have pain in the following areas? If yes, please elaborate.		
	<input type="checkbox"/> Neck:		X
	<input type="checkbox"/> Upper Back:		X
	<input type="checkbox"/> Shoulders:		X
	<input type="checkbox"/> Elbows:		X
	<input type="checkbox"/> Lower Back:	X	
	<input type="checkbox"/> Hips:		X
	<input type="checkbox"/> Wrists:		X
	<input type="checkbox"/> Knees:		X
6.	Have you had surgery in the past two years? If yes, when and for what:		X
7.	Are you currently undergoing treatment from any of the following? If yes, why? Occasional lower back pain from occupation		
	<input type="checkbox"/> Physiotherapist		X
	<input type="checkbox"/> Chiropractor		X
	<input type="checkbox"/> Massage Therapist	X	
	<input type="checkbox"/> Other Practitioner		X
8.	Are you pregnant now, planning to be or have been in the past 6 months?	X	
9.	Are you over 50 years of age?		X
10.	Do you have any physical limitations/injuries?		X
11.	Is there any reason not mentioned above, why you feel you should not participate in a regular physical exercise program?		X

If you answered YES to any of the above questions, please consult with your health care practitioner prior to taking part in an exercise program. Listen to any special advice or recommendations made by this specialist.

If you have answered NO to all of the above questions, you can be reasonably assured of your present suitability to take part in an exercise program designed by your trainer.

I, Case Study – Michelle declare that the information given her by me is true and correct to the best of my knowledge. Any health problems which would prevent me from engaging in physical activities or make it potentially dangerous or harmful for me to engage in such activities have been described here by me.

Michelle Case Study
Signature of Participant

14 April, 2004
Date

CASE STUDY #1 – LIFESTYLE QUESTIONNAIRE

Name: Case Study #1 – Michelle

Date: 14 April, 2004

Physical Activity

1. In the past year, how often have you been engaged in physical activity?

- > 4 times/week
 3 to 4 times/week
 2 to 3 times/week
 1 to 2 times/week
 1 to 2 times/month
 None

2. List your current physical activities: Walks, recreational softball

3. What types of physical activity do you consider “fun”? Softball

4. What types of exercise interest you?

- | | | |
|---|---|---|
| <input checked="" type="checkbox"/> Walking | <input type="checkbox"/> Jogging | <input type="checkbox"/> Swimming |
| <input checked="" type="checkbox"/> Cycling | <input type="checkbox"/> Dance Exercise | <input checked="" type="checkbox"/> Strength Training |
| <input type="checkbox"/> Stationary biking | <input type="checkbox"/> Rowing | <input type="checkbox"/> Racquetball |
| <input type="checkbox"/> Tennis | <input checked="" type="checkbox"/> Other aerobic | <input type="checkbox"/> Stretching |

Support/Exercise Adherence

5. What are your personal barriers to exercise (i.e., your reasons for not exercising)? Lack of time

6. What physical activity have you been successful with in the past (liked and participated in regularly)? Walking

7. Have you ever been at your desired fitness level? Yes No

If yes, when? _____ What were you doing? _____

8. Do you feel any family; friends or co-workers have negative feelings (i.e., disapproval, resentment) toward your efforts at physical activity?

Yes No

9. Is your significant other or a close friend involved in any regular physical activity and supportive in your physical activity goals?

Yes No

10. Do you start exercise programs but then find yourself unable to stick with them? Yes No

Occupation/Leisure

11. What is your present occupation? Teacher's Assistant

12. Does your occupation require much activity (i.e., walking, getting up and down, carrying things)?

Yes, walking, kneeling, bending and standing

13. What are your usual leisure activities? Watching movies

14. What are the physical demands of these activities? None

Stressors

15. What types of things make you feel stressed? Lack of money and job security

16. How do you deal with your stress normally? I don't

Dietary Patterns

17. How many meals do you have per day? 3 per day

18. How many snacks do you have per day? None

19. Do you feel you eat healthy “most of the time”? Yes

20. How many glasses of water do you drink per day? 3 per day

Expectations

21. Specifically describe what you would like to accomplish through your fitness program during the next:

1 month: Safe exercises to perform during my pregnancy

4 months: Maintain a healthy weight gain during my pregnancy

1 year: Return to pre-pregnancy weight

Case Study #1 - Ben

CASE STUDY #2

Ben is a 42 year old owner of a website design company. Before starting his company 8 years ago, he used to be very active lifting weights 2x a week and running on the weekends. He now finds that he only has time to play rugby 2x a week after work because he typically works 8-10 hours per day. Lately he has been noticing that he feels a dull ache in the centre of his right knee after rugby. Ben would like to start working out in the weight room again because he feels that he is not doing enough. He would also like to run a 10km race in the next year. His main concern is time and his knee. He has also started to notice that his once in-shape, toned body is starting to feel flabby. He would like you to set him up on a program that he can do a few times a week.

Phase I Situation

His Goals	<ul style="list-style-type: none"> ▪ Start working out in the weight room again ▪ Wants to lose some weight ▪ Wants to manage his knee pain
Height	5 ft. 7 in.
Weight	200 lbs.
Resting BP	120/80 mmHG
Resting HR	85 bpm
Blood Lipids	Total Cholesterol = 5.0 mmol/l (196 mg/dl) HDL = 1.0 mmol/l (37 mg/dl) LDL = 3.0 mmol/l (115 mg/dl)
Medication	Advil for knee pain
Max METS	8 METS or a Max VO_2 of 28.0 ml/kg/min
Availability	After work around 8 pm; 3x/week
Activities	Rugby after work for 2 hours, 2x/week
Injuries	Knee pain during and after his rugby games
Medical Diagnosis & Prescription	<ul style="list-style-type: none"> ▪ Exercise prescription from physiotherapist ▪ Patellofemoral Stress Syndrome ▪ Stretch Hamstrings, Gastrocnemius, IT Band ▪ Strengthen and balance VMO and VL ▪ Watch for proper patellar tracking and over pronation of the foot
Lifestyle	<ul style="list-style-type: none"> ▪ Non-smoker, social drinker (3-5 glasses of wine a week) ▪ Eats out a lot at fast food places ▪ Sits at a computer for most of the day and talks on the phone ▪ Some low back stiffness and definite forward head posture ▪ Single, sleeps 6-7 hours a night and often has a hard time falling asleep at night

Phase II Situation

1 year later; he has been working out consistently with weight 2x/week: RHR 70 bpm; knee pain is gone; running 2x/week 1 hour per session; wants to start building size.

CASE STUDY #2 – HEALTH SCREENING QUESTIONNAIRE

Taking part in any activity or exercise program can be an excellent way to improve or maintain your health and fitness levels, but preparation is required to enable a safe and effective program. Please answer the following questions to assess your own physical readiness:

		Yes	No
1.	Do you have any health or medical concerns? If yes, please specify knee pain	X	
2.	Are you currently taking any medication? If yes, list medications and for what condition Medication <u>Advil</u> Condition <u>sore knee</u> Medication _____ Condition _____	X	
3.	Do you smoke? If yes, how much? _____		X
4.	Do you, or have you ever had, any of the following health conditions?		
	<input type="checkbox"/> Blood Pressure Concerns:		X
	<input type="checkbox"/> Heart Murmur:		X
	<input type="checkbox"/> Any heart trouble:		X
	<input type="checkbox"/> Chest pains/pressure:		X
	<input type="checkbox"/> Disease of arteries:		X
	<input type="checkbox"/> Asthma/allergies:		X
	<input type="checkbox"/> High Cholesterol:		X
	<input type="checkbox"/> Back injury		X
	<input type="checkbox"/> Back pains:		X
	<input type="checkbox"/> Epilepsy:		X
	<input type="checkbox"/> Diabetes:		X
	<input type="checkbox"/> Varicose veins:		X
	<input type="checkbox"/> Lung Disease:		X
	<input type="checkbox"/> Dizziness/Fainting spells:		X
	<input type="checkbox"/> Arthritis:		X
	<input type="checkbox"/> Osteoporosis:		X
5.	Have you ever injured or have pain in the following areas? If yes, please elaborate.		
	<input type="checkbox"/> Neck:		X
	<input type="checkbox"/> Upper Back:		X
	<input type="checkbox"/> Shoulders:		X
	<input type="checkbox"/> Elbows:		X
	<input type="checkbox"/> Lower Back:		X
	<input type="checkbox"/> Hips:		X
	<input type="checkbox"/> Wrists:		X
	<input type="checkbox"/> Knees:	X	
6.	Have you had surgery in the past two years? If yes, when and for what:		X
7.	Are you currently undergoing treatment from any of the following? If yes, why? Patella femoral stress syndrome		
	<input type="checkbox"/> Physiotherapist	X	
	<input type="checkbox"/> Chiropractor		X
	<input type="checkbox"/> Massage Therapist		X
	<input type="checkbox"/> Other Practitioner		X
8.	Are you pregnant now, planning to be or have been in the past 6 months?		X
9.	Are you over 50 years of age?		X
10.	Do you have any physical limitations/injuries?	X	
11.	Is there any reason not mentioned above, why you feel you should not participate in a regular physical exercise program?		X

If you answered YES to *any* of the above questions, please consult with your health care practitioner prior to taking part in an exercise program. Listen to any special advice or recommendations made by this specialist.

If you have answered NO to *all* of the above questions, you can be reasonably assured of your present suitability to take part in an exercise program designed by your trainer.

I, Case Study – Ben declare that the information given her by me is true and correct to the best of my knowledge. Any health problems which would prevent me from engaging in physical activities or make it potentially dangerous or harmful for me to engage in such activities have been described here by me.

Ben Case Study
Signature of Participant

6 June, 2004
Date

CASE STUDY #2 – LIFESTYLE QUESTIONNAIRE

Name: Case Study #2 – Ben

Date: 6 June, 2004

Physical Activity

1. In the past year, how often have you been engaged in physical activity?

- > 4 times/week
 3 to 4 times/week
 2 to 3 times/week
 1 to 2 times/week
 1 to 2 times/month

None

2. List your current physical activities: Rugby 2 x per week

3. What types of physical activity do you consider “fun”? Rugby

4. What types of exercise interest you?

- | | | |
|--|---|---|
| <input type="checkbox"/> Walking | <input checked="" type="checkbox"/> Jogging | <input type="checkbox"/> Swimming |
| <input type="checkbox"/> Cycling | <input type="checkbox"/> Dance Exercise | <input checked="" type="checkbox"/> Strength Training |
| <input type="checkbox"/> Stationary biking | <input type="checkbox"/> Rowing | <input checked="" type="checkbox"/> Racquetball |
| <input type="checkbox"/> Tennis | <input checked="" type="checkbox"/> Other aerobic | <input type="checkbox"/> Stretching |

Support/Exercise Adherence

5. What are your personal barriers to exercise (i.e., your reasons for not exercising)? Job; computer; tired

6. What physical activity have you been successful with in the past (liked and participated in regularly)? Weight Training

7. Have you ever been at your desired fitness level? Yes No

If yes, when? 8 years ago What were you doing? Running and weight training

8. Do you feel any family; friends or co-workers have negative feelings (i.e., disapproval, resentment) toward your efforts at physical activity?

Yes No

9. Is your significant other or a close friend involved in any regular physical activity and supportive in your physical activity goals?

Yes No

10. Do you start exercise programs but then find yourself unable to stick with them? Yes No

Occupation/Leisure

11. What is your present occupation? Website Designer

12. Does your occupation require much activity (i.e., walking, getting up and down, carrying things)? No

13. What are your usual leisure activities? Eating out

14. What are the physical demands of these activities? None

Stressors

15. What types of things make you feel stressed? Lack of time

16. How do you deal with your stress normally? Drinks

Dietary Patterns

17. How many meals do you have per day? 2 per day

18. How many snacks do you have per day? 3 snacks per day

19. Do you feel you eat healthy “most of the time”? No

20. How many glasses of water do you drink per day? None, 5 cups of coffee per day

Expectations

21. Specifically describe what you would like to accomplish through your fitness program during the next:

1 month: Decrease knee pain

4 months: Lose 20 lbs.

1 year: Run the 10km. Sun Run Race

Case Study #3 - Donald

CASE STUDY #3 – SCENARIO

Donald is a 69 year old retired farmer whose physical activity has decreased since selling his farm. He and his wife want to travel, but he is having a hard time getting around due to osteoarthritis gradually developing in his hips. He also has a family history of diabetes and he is borderline himself, but not yet on medication. His doctor recommends exercise to help control it. He has gained about 15 lbs. since retiring and has gone up 2 waist sizes. Donald takes Tylenol for his arthritis and is trying mint tea to combat the possible diabetes onset. He used to enjoy curling once a week with his wife, five years ago. He has had several farm related injuries over the years, but he has healed well. Donald has plenty of free time and would like to improve his fitness level for a short trip he has planned in 3 months.

Phase I Situation

His Goals	<ul style="list-style-type: none"> ▪ Prevent onset of diabetes ▪ Lose 15 lbs. ▪ Increase mobility and independent living
Height	5 ft. 8 in.
Weight	185 lbs.
Resting BP	142/85 mmHG
Resting HR	74 bpm
Blood Lipids	Not available
Medication	Tylenol for arthritis
Max METS	Not available
Availability	Flexible
Activities	Seasonal homeowners chores (lawn cutting, etc.); walks 1x/week with wife
Injuries	Low back pain; treated by physiotherapist 5 years ago
Medical Diagnosis & Prescription	Physician prescribes exercise <ul style="list-style-type: none"> ▪ Borderline diabetic ▪ Borderline hypertensive
Lifestyle	<ul style="list-style-type: none"> ▪ Non-smoker, social drinker (6 beers a week) ▪ Predominantly meat and potatoes diet ▪ Watches a lot of TV ▪ Some low back stiffness

Phase II Situation

6 months later; he has been weight training consistently 2x/week and cardio 3x/week

CASE STUDY #3 – HEALTH SCREENING QUESTIONNAIRE:

Taking part in any activity or exercise program can be an excellent way to improve or maintain your health and fitness levels, but preparation is required to enable a safe and effective program. Please answer the following questions to assess your own physical readiness:

		Yes	No
1.	Do you have any health or medical concerns? If yes, please specify <u>Osteoarthritis of the hip; borderline diabetic; borderline high blood pressure</u>	X	
2.	Are you currently taking any medication? If yes, list medications and for what condition Medication <u>Tylenol</u> Condition <u>Arthritis</u> Medication _____ Condition _____	X	
3.	Do you smoke? If yes, how much? _____		X
4.	Do you, or have you ever had, any of the following health conditions?		
	<input type="checkbox"/> Blood Pressure Concerns:	X	
	<input type="checkbox"/> Heart Murmur:		X
	<input type="checkbox"/> Any heart trouble:		X
	<input type="checkbox"/> Chest pains/pressure:		X
	<input type="checkbox"/> Disease of arteries:		X
	<input type="checkbox"/> Asthma/allergies:		X
	<input type="checkbox"/> High Cholesterol:		X
	<input type="checkbox"/> Back injury		X
	<input type="checkbox"/> Back pains:		X
	<input type="checkbox"/> Epilepsy:		X
	<input type="checkbox"/> Diabetes:	X	
	<input type="checkbox"/> Varicose veins:		X
	<input type="checkbox"/> Lung Disease:		X
	<input type="checkbox"/> Dizziness/Fainting spells:		X
	<input type="checkbox"/> Arthritis:	X	
	<input type="checkbox"/> Osteoporosis:		X
5.	Have you ever injured or have pain in the following areas? If yes, please elaborate.		
	<input type="checkbox"/> Neck:		X
	<input type="checkbox"/> Upper Back:		X
	<input type="checkbox"/> Shoulders:		X
	<input type="checkbox"/> Elbows:		X
	<input type="checkbox"/> Lower Back:		X
	<input type="checkbox"/> Hips:	X	
	<input type="checkbox"/> Wrists:		X
	<input type="checkbox"/> Knees:		X
6.	Have you had surgery in the past two years? If yes, when and for what:		X
7.	Are you currently undergoing treatment from any of the following? If yes, why?		
	<input type="checkbox"/> Physiotherapist		X
	<input type="checkbox"/> Chiropractor		X
	<input type="checkbox"/> Massage Therapist		X
	<input type="checkbox"/> Other Practitioner		X
8.	Are you pregnant now, planning to be or have been in the past 6 months?		X
9.	Are you over 50 years of age?	X	
10.	Do you have any physical limitations/injuries?	X	
11.	Is there any reason not mentioned above, why you feel you should not participate in a regular physical exercise program?		X

If you answered YES to any of the above questions, please consult with your health care practitioner prior to taking part in an exercise program. Listen to any special advice or recommendations made by this specialist.

If you have answered NO to all of the above questions, you can be reasonably assured of your present suitability to take part in an exercise program designed by your trainer.

I, Case Study –Donald declare that the information given her by me is true and correct to the best of my knowledge. Any health problems which would prevent me from engaging in physical activities or make it potentially dangerous or harmful for me to engage in such activities have been described here by me.

Donald Case Study
Signature of Participant

16 October, 2004
Date

CASE STUDY #3 – LIFESTYLE QUESTIONNAIRE

Name: Case Study #3 – Donald Date: 16 October, 2004

Physical Activity

1. In the past year, how often have you been engaged in physical activity?

- > 4 times/week
 3 to 4 times/week
 2 to 3 times/week
 1 to 2 times/week
 1 to 2 times/month
 None

2. List your current physical activities: Walking and seasonal homeowners activities (cutting grass, etc.)

3. What types of physical activity do you consider "fun"? Curling

4. What types of exercise interest you?

- | | | |
|---|---|---|
| <input checked="" type="checkbox"/> Walking | <input type="checkbox"/> Jogging | <input type="checkbox"/> Swimming |
| <input type="checkbox"/> Cycling | <input type="checkbox"/> Dance Exercise | <input checked="" type="checkbox"/> Strength Training |
| <input type="checkbox"/> Stationary biking | <input type="checkbox"/> Rowing | <input type="checkbox"/> Racquetball |
| <input type="checkbox"/> Tennis | <input type="checkbox"/> Other aerobic | <input type="checkbox"/> Stretching |

Support/Exercise Adherence

5. What are your personal barriers to exercise (i.e., your reasons for not exercising)? Lack of mobility

6. What physical activity have you been successful with in the past (liked and participated in regularly)? Curling

7. Have you ever been at your desired fitness level? Yes No

If yes, when? Pre-retirement What were you doing? Farming

8. Do you feel any family; friends or co-workers have negative feelings (i.e., disapproval, resentment) toward your efforts at physical activity?

Yes No

9. Is your significant other or a close friend involved in any regular physical activity and supportive in your physical activity goals?

Yes No

10. Do you start exercise programs but then find yourself unable to stick with them? Yes No N/A

Occupation/Leisure

11. What is your present occupation? Retired Farmer

12. Does your occupation require much activity (i.e., walking, getting up and down, carrying things)? No

13. What are your usual leisure activities? Watching TV

14. What are the physical demands of these activities? None

Stressors

15. What types of things make you feel stressed? Age/mobility

16. How do you deal with your stress normally? N/A

Dietary Patterns

17. How many meals do you have per day? 3 per day

18. How many snacks do you have per day? Varies/evening

19. Do you feel you eat healthy "most of the time"? Yes

20. How many glasses of water do you drink per day? 2-3 per day

Expectations

21. Specifically describe what you would like to accomplish through your fitness program during the next:

1 month: Decrease hip pain and increase mobility

4 months: Lose 15 lbs.

1 year: Return to pre-retirement activity level