RED ROCKS COMMUNITY COLLEGE
STUDENT RECREATION CENTER

FIT-WELL PERSONAL TRAINING PROGRAM APPLICATION

Date _____ Name_____

Phone_____ Email_____

S-Number: _____ Status: ☐ Student ☐ Faculty/Staff/Admin ☐ Guest

Have you worked with an SRC Personal Trainer before? ☐ Yes ☐ No

If yes, what trainer did you work with? _____

Do you prefer a male or female trainer? ☐ Male ☐ Female ☐ No Preference

Specific Trainer Requested? List Name(s) _____

Have you currently been exercising for at least 30 mins/day, 3 days/week, at a moderate intensity for the last 3 months? ☐ **Yes** ☐ **No**

What are your current fitness goals (please be as specific as possible)?

_____

_____

Please select the packages/sessions you may be interested in purchasing (**Rates** - Student/Faculty-Staff):

☐ Fitness Session (1-hour) **($20/$30)**
☐ Buddy Session Package **(Varies)**
☐ Starter Fitness Package **($100/$150)**
☐ Comprehensive Fitness Assessment **($20/$30)**
☐ Health Assessment **($15/$20)**

Number of Sessions: _____
Name of Buddy: _____
☐ Ultimate Fitness Package **($220/$350)**
☐ Fitness Consultation **($15/$20)**

Please find detailed descriptions of packages and trainer profiles on our website at www.rrcc.edu/src

When are you available to train (**check all that apply - please be as flexible as possible**)?

Sunday	**Monday**	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Saturday**
CLOSED	☐ 6:30am-8am	☐ 6:30am-8am	☐ 6:30am-8am	☐ 6:30am-8am	☐ 6:30am-8am	☐ 10:30am-12pm
	☐ 8am-10am	☐ 8am-10am	☐ 8am-10am	☐ 8am-10am	☐ 8am-10am	☐ 12pm-1pm
	☐ 10am-12pm	☐ 10am-12pm	☐ 10am-12pm	☐ 10am-12pm	☐ 10am-12pm	☐ 1pm-3pm
	☐ 12pm-2pm	☐ 12pm-2pm	☐ 12pm-2pm	☐ 12pm-2pm	☐ 12pm-2pm	☐ 3pm-5pm
	☐ 2pm-4pm	☐ 2pm-4pm	☐ 2pm-4pm	☐ 2pm-4pm	☐ 2pm-4pm	
	☐ 4pm-6pm	☐ 4pm-6pm	☐ 4pm-6pm	☐ 4pm-6pm	☐ 4pm-6pm	
	☐ 6pm-9pm	☐ 6pm-9pm	☐ 6pm-9pm	☐ 6pm-9pm		

Please submit this form to the Student Recreation Center email, src@rrcc.edu (OR) please complete and drop this form off at the Student Recreation Center Service Desk.

NOTE: Payment for personal training session(s) will ONLY be made once client has successfully completed and submitted application for processing and has been placed with an SRC personal trainer.

Fitness Coordinator Use Only

Date of paperwork received _____ Date contacted _____

Date client was placed _____ Name of Trainer _____

Student Recreation Center Personal Training Program Registration & Waiver Form

Please print legibly or type below:

Name: _____ **Phone:** _____

Mailing Address: _____
Street **City** **Zip Code**

Email Address: _____ **S-Number:** _____

Date of Birth: _____ **Age:** _____ **Gender:** _____

Emergency Contact: _____ **Phone:** _____

**** Credit Cards (Visa, MC, American Express, Discover) are acceptable forms of payment. Cash accepted at the Cashier's Office****

SRC Personal Training Program policies:

- Each participant must sign a [this] waiver, a complete health and exercise history questionnaire and a PAR-Q form to be kept on file. These documents will be confidential between the Fitness Coordinator, personal trainer, and the client.
- The personal trainer must be notified at least 24 hours in advance for cancellations; if notification is not at least 24 hours in advance or the session is missed (no call, no show) the participant will be charged for the session missed;
- Every client is given one (1) excusal for either notifying their personal trainer with less than 24 hours' advance notice for a cancellation or for a no call, no show to a training session;
- With advanced notice, participants that show up late to a session will still be charged for the full session. Note that the training session will only continue for the duration of the scheduled session (i.e. if training session started at 1pm and client showed up at 1:15pm, the session will still end at 2pm – it will not be extended to 2:15pm);
- The personal trainer will wait up to 15 minutes (without prior notice from client) for client session(s). Trainers will leave after 15 minutes and count session as a no-call, no-show;
- Clients are to meet the personal trainer at the SRC Service Desk at the scheduled appointment time, unless an alternate meeting place (must be on RRCC campus) has been agreed upon between client and the personal trainer.
- Note: The 'Ultimate Fitness Package' has a specific expiration date (8-weeks from purchase date). All other sessions can be used within 1-year from purchase date;
- Clients may not share personal training sessions with other SRC members;
- Refunds are provided on a case-by-case basis. Refunds are only available for sessions/percent of packages not already used.

Red Rocks Community College Assumption of Risk for Participation in Recreational and Programed Activities

Each participant in the SRC Personal Training Program should realize that there are substantial risks, hazards, and danger inherent in such training. Each participant in the SRC Personal Training Program must be covered by an accident and health insurance policy. It is the responsibility of each participant to participate only in those activities for which he/she has the prerequisite skills, qualifications, preparation, and training (as determined and instructed by the personal trainer). The College does not warrant or guarantee in any respect the competence or mental or physical condition of any personal trainer. The College also does not warrant or guarantee in any respect the physical condition or any equipment used in connection with the activity.

Therefore, in consideration of the benefits received from the Student Recreation Department, the undersigned assumes all risks of damages or injury, including death, that may be sustained by him/her/them while participating in any and all recreational activity or in travel to or from such activity.

Release, Covenant Not to Sue, and Waiver

Personal Training involves an inherent risk of physical injury and the undersigned assumes all such risks. The undersigned hereby agrees that for the sole consideration of Red Rocks Community College allowing the undersigned to participate in the SRC Personal Training Program for which or in connection with which the College has made available any equipment, facilities, grounds, or personnel for such training, the undersigned does hereby release, covenant not to sue, and forever discharge the State of Colorado, State Board for Community Colleges and Occupational Education ("SBCCOE" or "Board"), Red Rocks Community College ("RRCC" or "College" or "the College") and its trustees, officers, agents, and employees of any and for all claims, demands, rights, and causes of action of whatever kind or nature including but not limited to negligence, unforeseen bodily and personal injuries, damage to property, and the consequences thereof resulting from participation in any way connected with such recreational programs and activities. I understand that this Release, Covenant Not to Sue, Waiver, and Assumption of Risk shall cover any and all recreational and structured programing activities in which I participate. By signing this document, the undersigned hereby acknowledges that he/she/they has read the above carefully before signing, and agrees to comply with all the above.

Signature: _____ **Date:** _____

Signature of Parent/Guardian – one signature required if participant is 17 years old or younger:

_____ _____ _____
Parent Name (Print Name) **Parent Signature** **Date**

Address and Phone:

_____

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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 International Physical Activity Guidelines for your age (www.who.int/dietphysicalactivity/en/).
- 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 have a temporary illness such as a cold or fever; it is best to wait until you feel better.
- You are pregnant - talk to your health care practitioner, your physician, a 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 doctor or a qualified exercise professional before continuing with any physical activity program.

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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 chemotheraphy 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 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 ☐

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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.

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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 have a temporary illness such as a cold or fever; it is best to wait until you feel better.
- You are pregnant - talk to your health care practitioner, your physician, a qualified exercise professional, and/or complete the ePARmed-X+ **at www.eparmedx.com** before becoming more physically active.
- Your health changes - talk to your doctor 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+
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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.

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11-01-2018

EXERCISE HISTORY AND ATTITUDE QUESTIONNAIRE

Name _____ Date _____

General Instructions: Please fill out this form as completely as possible. If you have any questions, DO NOT GUESS.

1. Please rate your exercise level on a scale of 1 to 5 (5 indicating very strenuous) for each age range through your present age:
   15–20 Select 21–30 Select 31–40 Select 41–50 Select 51+ Select

2. Were you a high school and/or college athlete?
   ❑ Yes ❑ No If yes, please specify _____

3. Do you have any negative feelings toward, or have you had any bad experience with, physical-activity programs?
   ❑ Yes ❑ No If yes, please explain_____

4. Do you have any negative feelings toward, or have you had any bad experience with, fitness testing and evaluation?
   ❑ Yes ❑ No If yes, please explain_____

5. Rate yourself on a scale of 1 to 5 (1 indicating the lowest value and 5 the highest).

	Check next to the number that best applies:				
Characterize your present athletic ability.	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
When you exercise, how important is competition?	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
Characterize your present cardiovascular capacity.	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
Characterize your present muscular capacity.	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
Characterize your present flexibility capacity.	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐

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

7. How much time are you willing to devote to an exercise program? _____ minutes/day _____ days/week

8. Are you currently involved in regular endurance (cardiovascular) exercise?
   ❑ Yes ❑ No If yes, specify the type of exercise(s) _____

   _____ minutes/day _____ days/week

   Rate your perception of the exertion of your exercise program (check the box):

   ❑ Light ❑ Fairly light ❑ Somewhat hard ❑ Hard

9. How long have you been exercising regularly?_____ months _____ years

Continued on next page

10. What other exercise, sport, or recreational activities have you participated in?

In the past 6 months?_____

In the past 5 years? _____

11. Can you exercise during your work day? ❑ Yes ❑ No

12. Would an exercise program interfere with your job? ❑ Yes ❑ No

13. Would an exercise program benefit your job? ❑ Yes ❑ No

14. What types of exercise interest you?

❑ Walking	❑ Jogging	❑ Strength training
❑ Cycling	❑ Traditional aerobics	❑ Racquet sports
❑ Stationary biking	❑ Elliptical striding	❑ Yoga/Pilates
❑ Stair climbing	❑ Swimming	❑ Other activities

15. Rank your goals in undertaking exercise: What do you want exercise to do for you?
Use the following scale to rate each goal separately. Check next to the number that best applies:

	Not at all important				Somewhat important					Extremely important
a. Improve cardiovascular fitness	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐	8 ☐	9 ☐	10 ☐
b. Lose weight/body fat	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐	8 ☐	9 ☐	10 ☐
c. Reshape or tone my body	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐	8 ☐	9 ☐	10 ☐
d. Improve performance for a specific sport	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐	8 ☐	9 ☐	10 ☐
e. Improve moods and ability to cope with stress	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐	8 ☐	9 ☐	10 ☐
f. Improve flexibility	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐	8 ☐	9 ☐	10 ☐
g. Increase strength	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐	8 ☐	9 ☐	10 ☐
h. Increase energy level	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐	8 ☐	9 ☐	10 ☐
i. Feel better	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐	8 ☐	9 ☐	10 ☐
j. Increase enjoyment	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐	8 ☐	9 ☐	10 ☐
k. Social interaction	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐	8 ☐	9 ☐	10 ☐
i. Other	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐	8 ☐	9 ☐	10 ☐

16. By how much would you like to change your current weight?

(+) _____ lb (–) _____ lb

SUBMIT APPLICATION HERE

or email completed application to src@rrcc.edu

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