Fitness Concepts
www.Fitness-Concepts.com
Info@Fitness-Concepts.com

VO_2 Max Test Instructions

Congratulations on signing up for a VO_2 Max test with Fitness Concepts. The results of this test will help you to train far more efficiently.

Please fill out and bring a copy of our Physical Activity Readiness Questionnaire (PAR-Q) with you. We will require the doctor's release only if you answer "yes" to any of the questions on page 5 of this document.

Make sure you are well rested for the test. Do not exercise the day of the test and keep workouts the day before relatively light. Do not eat or consume caffeine for 3 hours prior to the test, but be well hydrated.

Bring a heart rate monitor with you if you have one. If you don't, we have monitors you can use during your test. Bring running shoes and clothing if you plan to test on the treadmill or your bike, shoes, and cycling clothing if you plan a bike test.

We currently offer testing primarily at our Falls Church location, 6208 Waterway Dr, Falls Church, VA 22044. **Enter at the lower level.**

Directions are as follows:

- Take the beltway to route 50 East in Fairfax, Va
- Go about 4 miles and, right after McDonalds, turn right on Annandale Rd.
- Go about 1 mile and turn left on Kerns rd. Go about a mile to the first light and turn left on Sleepy Hollow.
- Go about 1 mile and turn right on Valley Dr.
- Take the next right on Villa Ln
- Go about 1/4 mile and turn right on Potterton. At the bottom of the hill, you will cross a small bridge.
- Take the next right and an immediate left up a very steep driveway.
- Park on the street or on the middle level, not the upper level
- For group tests, most participants will park on the street
- Take the stairs down to the lower level and enter through the sliding glass doors.
- Please come in at your appointment time even if we are still with the previous tester. The appointments usually overlap slightly and we may begin the next tester's warm-up while we complete the explanation of previous appointment's test results.

We occasionally test at other locations as well, so please check the address listed in your registration.

You will warm up at a very light intensity for about 15 minutes. During the test you will wear a neoprene mask connected by hoses to a metabolic analyzer. We will measure the volume of air expired along with the concentrations of carbon dioxide and oxygen in your expired air.

The test will begin at a very light intensity and increase slightly every minute until you cannot go anymore. Generally tests last between 16 and 20 minutes. Most of the test will be relatively easy, but the last several minutes will be very difficult.

Ride or run at your normal cadence/turnover and use the same techniques you do in training and racing. The more closely we can duplicate your training and racing conditions, the more applicable the results will be. This is VERY important.

Based on the results we will determine:

- **Aerobic Threshold**: Aerobic threshold is the intensity at which you recruit all of your slow-twitch (endurance) fibers but none of the fast-twitch fibers. This is also the intensity of optimal fat burning.

- **Lactate Threshold**: Lactate threshold is the highest intensity at which you remove lactic acid from the muscles as quickly as you produce it. Training slightly below this intensity is very efficient.

- **VO_2 Max**: VO_2 Max, or maximal aerobic capacity, is the amount of oxygen that your muscles can use in one minute of maximal exertion.

From the above information, we will determine specific heart rate zones for your unique physiology for each type of workout. Your results will come in a 14-page booklet explaining how to best use the test results to optimize your training.

Please write us at Info@Fitness-Concepts.com with any questions.

We look forward to testing you,

Fitness Concepts

Fitness Concepts
www.Fitness-Concepts.com
Info@Fitness-Concepts.com

Informed Consent

Client Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Email: _____ Fax: _____

This contract is being entered into between Ultrafit Washington D.C. (trading as Fitness Concepts) and (client) _____ for fitness training and consultation. I understand and agree to the business procedures of Fitness Concepts Inc.

I, (client) _____ am committing voluntarily to making a positive change in my health through participation in this program. I understand that certain elements of this program may be physically demanding and that I will need to change various aspects of my lifestyle in order to realize the goals I have established for myself in this program.

As a condition of my enrollment, I accept full and complete responsibility for my ability to healthfully participate in this program. This means that I acknowledge Fitness Concepts' recommendation that I obtain physician's approval of my participation in this program. I agree to hold Fitness Concepts, it's officers, employees, agents, successors, and assigns free and harmless of any and all liability for subsequent injury or health related problem that may result from or be aggravated by my participation in this program.

I understand that I am responsible for monitoring my own condition throughout each exercise session and, should any unusual symptoms occur I will cease participation and inform the trainer of these symptoms.

I realize that Fitness Concepts is responsible only for providing the coaching I requested by hiring these services. I am responsible for my own participation, for my own physical and emotional well-being, and for the attainment of the goals I have established for this program. I understand that participation in this program may cause unforseen injury. I agree to hold Fitness Concepts, it's officers, employees, agents, successors, and assigned free from any and all liability in connection with my performance and accept any risk which is associated with my participation in this program.

In signing this consent form, I affirm that I have read this form in its entirety and that I understand the nature of the exercise program. I also affirm that all of my questions regarding the exercise program have been answered to my satisfaction.

Client Signature: _____ Date: _____

Physical Activity Readiness Questionnaire

Initial Blood Pressure and Pulse Rate Examination

Completion of this form is mandatory for all clients in order to initiate an individualized vigorous conditioning program. This program will consist of physical training for: cardiovascular endurance, muscle strength and flexibility, dietary intervention, and stress management.

The initial blood pressure and pulse rate is required before further processing of your application for the conditioning program.

_____ _____

NAME **SIGNATURE**

_____ _____/_____ _____

DATE **BP** **PULSE RATE**

The PAR-Q and You

PAR-Q is designed to help you help yourself.. Many health benefits are associated with an individualized vigorous conditioning program. The accurate completion of the PAR-Q is a sensible first step to take if you are planning to vigorously increase the intensity or frequency of physical conditioning.

For some people vigorous physical conditioning may pose problems or hazards. The PAR-Q has been designed to identify adults for whom vigorous physical conditioning is or might be inappropriate or contraindicative. The PAR-Q has also been designed for those who should have medical advice concerning the type of vigorous physical conditioning most suitable to them.

Please check the YES or NO column opposite each question as it applies to you.

	YES	NO
1. Has your doctor ever informed you that you have heart trouble?	☐	☐
2. Do you frequently experience pains in your heart or chest?	☐	☐
3. Do you often feel faint or have spells of severe dizziness?	☐	☐
4. Has a doctor ever informed you that blood pressure is too high?	☐	☐
5. Has your doctor ever informed you of a bone or joint problem such as arthritis that has been aggravated by exercise or might be made worse with exercise?	☐	☐
6. Is there a good reason, not mentioned here, why you should not follow a vigorous conditioning program even if you wanted to?	☐	☐
7. Are you over 65 and not accustomed to vigorous exercise?	☐	☐

8. OTHER MEDICAL HISTORY: Please discuss any medical conditions that would be important to know related to designing, implementing and evaluating your individualized vigorous conditioning program: (i.e., low back pain, pregnancy, current illness, diabetes, high blood pressure, smoking, cartilage tear, any medications, etc.).
   DISCUSSION NOTES:_____
   _____
   _____
   _____
   _____

Medical Clearance: If you answered **YES** to any of the above questions or if there are any physical problems that would possibly impair your partaking in an individualized vigorous conditioning program or put you at any risks, be prepared to have a medical clearance form completed by your doctor **prior to starting** your individualized vigorous conditioning program.

A. Personal Information

_____ _____ _____
Last Name First MI Birth Date Sex

_____
Street Address City/State Zip

_____ _____ _____
Work Phone Home Phone Occupation

B. Date of last physical examination:_____

C. List any serious/chronic illness you are aware of:_____
_____

D. List any medication you have been on or are presently taking:

Type of Medication Dosage How long on it?

1._____

2._____

3._____

E. Indicate any injuries, past or present, or limitations that may affect your conditioning program:

Foot: L R_____
Ankle: L R_____
Knee: L R_____
Hip: L R_____
Hand: L R_____
Abdominal:_____

Shoulder: L R_____
Elbow: L R_____
Wrist: L R_____
Neck: _____
Back: _____

F. Family History YES NO

High Blood Pressure	☐	☐
Heart Attack/Stroke	☐	☐
Do you smoke	☐	☐
How Long	☐	☐
Diabetes	☐	☐

G. Are there any other limitations of problems that you feel might hinder you while participating in a vigorous exercise program? If so, describe here:_____
_____
_____
_____
_____

H. Please indicate your present exercise activity level:

Activity	Times Per Day	Days Per Week
_____	_____	_____
_____	_____	_____
_____	_____	_____

I. Indicate any exercise club memberships:_____
_____

J. Indicate whether or not you have used weight lifting equipment:_____
What type of equipment have you used?_____
_____
_____

K. Indicate any specific goals that you have of which exercise is a necessary part of meeting the goal:
Goals
1._____

2._____

3._____

MEDICAL CLEARANCE FORM

Required only if you answered yes to any of the questions on page 5.

Patient's Name:_____

Yes No

____ ____ May participate in the fitness program with no restrictions.

____ ____ May participate in the program, but the following RESTRICTIONS ARE URGED: _____
_____

____ ____ Should have a physical exam and a 12 lead exercise stress test before participation.

Please provide any additional information or recommendations that may be useful in prescribing and instituting a safe, effective individualized exercise program for your patient.

_____
_____
_____
_____
_____
_____

_____
Physician's Name (Type or Print)

_____ _____
Physician's Signature Date