Personal Training Program Information and Policies

Welcome to the Student Recreation Center’s (SRC) Personal Training Program!

We are delighted that you chose us as a part of your commitment to health and fitness. Our skilled fitness professionals are ready to provide you with the necessary information and motivation to help you reach and maintain your personal fitness goals.

The following information will provide you with important program policies.

**Payment**
Payment for sessions must be made in advance of meeting with your trainer. At the time of payment, you will receive a receipt that must be presented to your trainer.

**Expiration Date**
All SRC Personal Training sessions have an expiration date of 4-months from the date of purchase. After the expiration date, any remaining sessions will be invalid. Sessions can be frozen for medical purposes only and require medical documentation. Frozen sessions will be held for one year after which time any remaining sessions will become invalid.

**Cancellations**
In order to cancel or reschedule an appointment, you must contact your trainer at least 48 hours in advance of the scheduled appointment or you will be charged for that session. (NOTE: any exception to this policy will be made purely at the discretion of the trainer.) Similarly, if a trainer does not contact you at least 48 hours in advance to cancel or reschedule an appointment, you will receive a complimentary session.

**Tardiness**
All clients and trainers are required to be prompt. If a client arrives late, this time will be deducted from the session; alternatively, if a trainer arrives late, the amount of time will be added for an extended session. Please be advised that trainers are required to wait 15 minutes for a scheduled client, after which time the session is subject to cancellation and clients will be charged for a full session.

**Refunds and Credits**
SRC Personal Training does not offer refunds or credits, so please be sure that our services will match your needs before committing to payment. If you find that your needs change once you have begun, please let us know; we are eager to find a way to accommodate you within this program.

Please fill out and return the following forms to the SRC before your assessment.
- Informed Consent Waiver (1 page)
- Client Information (2 pages)
- Physical Readiness Questionnaire (1 page)
- Self-Assessment (1 page)
- Medical Authorization Form-if needed (1 page)
Informed Consent Waiver

I, ___________________________________, do hereby consent to participate in a personal training program that will include weight training and/or cardiovascular exercise. I have been informed and understand that physical exercise has been associated with certain risks, including but not limited to musculoskeletal injury, spinal injuries, abnormal blood pressure responses, and, in rare instances, heart attack or death. Every effort will be made to minimize these risks. Any information that is obtained regarding my fitness level and my progress will be treated as privileged and confidential and will not be released or revealed to any person other than my physician or the program’s Supervisor (for record keeping purposes) without my expressed written consent.

I have read and understand the foregoing consent to participation in said program. I am aware that I may discontinue participation in the program at any time that I see fit to do so, but no refund will be given. If at any time I have questions concerning the content, policies, or procedures regarding the personal training program. I will discuss these questions with my trainer or the program supervisor immediately.

In addition, I agree to the following:

a) assume all risk of injury and all risk of damage to or loss of property arising out of my participation in this program;

b) release, discharge, and waive any and all responsibility of the California State University and University Center from and against any liability of injury, including death, and for damage to or loss of property which may be suffered by the undersigned arising out of, or in any way connected with the participation in this program; and

c) indemnify and hold harmless the University, its officers, agents and employees from and against all liability, claims, demands, actions, loss, and damage arising out of my participation in said personal training program.

Consenting Signature:

Participant:_______________________________________ Date: __________________

Witness:___________________________________________ Date: __________________
Client Information

Name ___________________________ Gender _______ Age _______ Date of Birth (mm/dd/yyyy) _______

Address __________________________ City __________________________ State _______ Zip _______

Telephone (Day) ___________________________ (Evening) ___________ Email Address __________

Cardiovascular Risk
Please check any that apply and age of onset:

High Blood Pressure □ You □ Mother □ Father □ Grandparent
High Cholesterol □ You □ Mother □ Father □ Grandparent
Diabetes □ You □ Mother □ Father □ Grandparent
Heart Disease □ You □ Mother □ Father □ Grandparent
Bypass Surgery □ You □ Mother □ Father □ Grandparent
Stroke □ You □ Mother □ Father □ Grandparent

Do you presently smoke cigarettes? □ Yes □ No If yes, how many per day? _______
Have you ever quit smoking? □ Yes □ No If yes, how long ago did you quit? _______
Height _______ Current Weight _______ What was your weight at 21? _______

Personal History
Date of last physical examination _______ Stress test _______ Resting EKG _______
Date of last blood cholesterol test _______ Total Serum Cholesterol _______ HDL _______
Date of last blood pressure test _______ Blood Pressure _______

Has your doctor ever restricted your physical activities? □ Yes □ No If yes, please explain _______

Do you have any allergies? □ Yes □ No If yes, please list _______

Do you ever experience chest pains or tightness? □ Yes □ No
Do you ever experience unusual shortness of breath during mild physical activity? □ Yes □ No
Are you presently taking any medication? □ Yes □ No
If so, please list type and purpose _______

Do you ever experience dizziness during vigorous physical activity? □ Yes □ No
Have you ever passed out during vigorous physical activity? □ Yes □ No
Do you have any (other) medical conditions which limit your ability to exercise? □ Yes □ No
If yes, please explain _______

If you are female, are you currently pregnant? □ Yes □ No
Injuries
Please check any of the following injuries you have had and specify which bone, muscle, joint, etc., and the year the injury occurred:

- [ ] Broken Bones
- [ ] Joint injury or chronic pain
- [ ] Other
- [ ] Muscle strain/sprain
- [ ] Back injury or chronic pain
- [ ] Ligament, tendon, or cartilage injury
- [ ] Nerve entrapment (e.g. carpal tunnel syndrome)

Are you currently being treated for any of the above injuries?  [ ] Yes  [ ] No
If yes, please specify the type of treatment ____________________________________________________________
______________________________________________________________________________________________

Lifestyle
If you are employed, do you consider your job to be  [ ] sedentary  [ ] active?
Are you  [ ] generally sedentary  [ ] a weekend or vacation exerciser
- [ ] physically active once or twice a week
- [ ] physically active more often

Do you have a regular exercise program?  [ ] Yes  [ ] No  If yes, please describe______________________________________________________________

Do you currently take any nutritional supplements or follow any special diet (vegetarian, low-calorie, etc.)?  [ ] Yes  [ ] No
If yes, please specify: ____________________________________________________________

Mark the meals you consume in an average day (including snacks):
- [ ] Breakfast
- [ ] Snack
- [ ] Lunch
- [ ] Snack
- [ ] Dinner
- [ ] Snack

Indicate how you are dealing with daily stress:  Not Well 1 2 3 4 5 6 7 8 9 10 Well

Indicate your energy level:  Very Low 1 2 3 4 5 6 7 8 9 10 Very High

How many hours of sleep do you normally get?______________________________

Training Interest and Goals
How many sessions are you thinking of purchasing initially?______________________

Please check any activities in which you are interested in participating:
- [ ] Weight Training
- [ ] Aerobics
- [ ] Rowing
- [ ] Stairmaster
- [ ] Running
- [ ] Stationary Bike
- [ ] Swimming
- [ ] Triathlons
- [ ] Walking
- [ ] Other________________________

How much time do you want to spend working out?__________________________

Do you have any exercise equipment at home?  [ ] Yes  [ ] No ________________________________

List any specific exercises that do not interest you or might cause you pain or discomfort:______________________________

What goals do you have concerning your training and health? (i.e. weight loss, rehabilitation, etc.)________________________
How did you hear about SRC Personal Training?

What are your schedule preferences and/or limitations for working with a trainer?

Trainer preference  □ Male  □ Female  □ No Preference  Requested Trainer: ____________________________

Emergency Contact: Name ___________________________________________ Phone ________________________

Other Services
Please check any services you would be interested in scheduling with the HSU Human Performance Lab.

☐ Body Composition Assessments (Bod Pod, Underwater Weighing and/or Skinfold Thickness Measurements):
  Percent body fat
  Ratio of lean body weight to fat weight
  Student/Staff: $5.00  Community: $10.00

☐ Aerobic Fitness Assessments:
  Treadmill or Bike graded exercise test (GXT) -- maximal or submaximal test
  Personal medical history review
  Resting and exercise blood pressure
  GXT Max
  Student/Staff: $35.00  Community: $45.00
  GXT SubMax
  Student/Staff: $30.00  Community: $40.00

☐ Complete Health and Fitness Assessment:
  Body composition
  Aerobic Fitness
  Student/Staff: $45.00  Community: $65.00

I have read, understood, and completed this questionnaire. I have read and will comply with program information policies. Any questions I had were answered to my full satisfaction.

Name: ___________________________________________ Date: ________________

Signature: ___________________________________________ Witness: ___________________________________________

Signature of Parent/Guardian (If client is under 18): ___________________________________________

HSU Student Recreation Center Personal Training Program, Student Recreation Center-HSU, Arcata CA 95521
Phone: (707) 826-4197  ●  Fax: (707) 826-3354  ●  Email: src@humboldt.edu
Physical Activity Readiness Questionnaire

Regular physical activity is fun and healthy, and increasingly more people are starting to become more active every day. Being more active is very safe for most people. However, some people should check with their doctor before they start becoming much more physically active.

If you are planning to become much more physically active than you are now, start by answering the weight questions in the box below.

If you are above the age of 15, the questionnaire will tell you if you should check with your doctor before you start.

**American College of Sports Medicine (ACSM) guidelines require that men over the age of 45 and women over the age of 55 complete a “Medical Authorization Form” BEFORE training.**

I have read, understood and completed this questionnaire. Any questions I had were answered to my full satisfaction.

Name:__________________________________________     Date:__________________________

Signature:________________________________________  Witness:________________________________

Signature of Parent/Guardian:__________________________

<table>
<thead>
<tr>
<th>Readiness Questionnaire</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are you a man over the age of 45 or a woman over the age of 55 with a family history of heart disease?</td>
<td></td>
<td></td>
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<tr>
<td>Has your doctor ever said that you have a heart condition and that you should only do physical activity recommended by a doctor?</td>
<td></td>
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<tr>
<td>Do you feel pain in your chest when you do physical activity?</td>
<td></td>
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<tr>
<td>In the past month, have you had chest pain when you were not doing physical activity?</td>
<td></td>
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<tr>
<td>Do you lose your balance because of dizziness or do you ever lose consciousness?</td>
<td></td>
<td></td>
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<tr>
<td>Do you have a bone or joint problem that could be made worse by a change in your physical activity?</td>
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<tr>
<td>Is your doctor currently prescribing drugs (for example, water pills) for your blood pressure or heart condition?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you know of any other reason why you should not do physical activity?</td>
<td></td>
<td></td>
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**Questionnaire Results**

If you answered **YES** to one or more questions, you will need to complete the Medical Authorization Form BEFORE you meet with a trainer or become more physically active.

Tell your doctor about the Readiness Questionnaire and to which questions you answered **YES**.

NOTE: You may be able to do any activity you want – as long as you start slowly and build up gradually. Or, you may need to restrict your activities to those which are safe for you. Talk with your doctor about the kinds of activities you wish to participate in and follow his/her advice.

If you answered **NO** (honestly) to all Readiness Questionnaire questions you can be reasonably sure that you can become more physically active and take part in fitness appraisal / training.

Other Considerations:

- If you are or may be pregnant – talk with your doctor before you start becoming more active.

- If your health changes so that you then answer **YES** to any of the above questions, tell your fitness or health professional and discuss whether you should change your physical activity plan.

I have read, understood and completed this questionnaire. Any questions I had were answered to my full satisfaction.

Name:__________________________________________     Date:__________________________

Signature:________________________________________  Witness:________________________________

Signature of Parent/Guardian:__________________________

[Logo: SRC Personal Training]
Readiness Questionnaire Clarifications

For most people, physical activity should not pose any problem or hazard. The questionnaire has been designed to identify the small number of adults for whom physical activity might be inappropriate and those who should have medical advice concerning the type of activity most suitable.

1. **Has a doctor ever said that you have a heart condition and that you should only do physical activity recommended by a doctor?**
   
   Significance/clarification:
   
   Persons with known heart disease are at increased risk for cardiac complications during exercise. They should consult a physician and undergo exercise testing before starting an exercise program in order to ensure that exercise prescription follow standard guidelines for cardiac patients. Note: Medical supervision may be required during exercise training.

2. **Do you feel pain in your chest when you do physical activity?**
   
   Significance/clarification:
   
   See question 3.

3. **In the past month, have you had chest pain when you were not doing physical activity?**
   
   Significance/clarification:
   
   A physician should be consulted to identify the cause of the chest pain, whether it occurs at rest or with exertion. If ischemic in origin, the condition should be stabilized before starting an exercise program. Exercise testing should be performed with the patient on his or her usual medication and the exercise prescription formulated in accordance with standard guidelines for cardiac patients.

4. **Do you lose your balance because of dizziness or do you ever lose consciousness?**
   
   Significance/clarification:
   
   A physician should be consulted to establish the cause of these symptoms, which may be related to potentially life threatening medical conditions. Exercise training should not be undertaken until serious cardiac disorders have been excluded.

5. **Do you have a bone or joint problem that could be made worse by a change in your physical activity?**
   
   Significance/clarification:
   
   Existing musculoskeletal disorders may be exacerbated by inappropriate exercise training. Persons with forms of arthritis known to be associated with a systemic component (for example, rheumatoid arthritis) may be at an increased risk for exercise-related medical complications. A physician should be consulted to determine whether any special precautions are required during exercise training.

6. **Is your doctor currently prescribing drugs (for example, water pills) for your blood pressure or heart condition?**
   
   Significance/clarification:
   
   See question 1. Medication effects should be considered when formulating the exercise prescription. The exercise prescription should be formulated in accordance with guidelines or the specific cardiovascular disease for which medications are being used. A physician should be consulted to determine whether the condition of factor requires special precautions during exercise training or contraindicates exercise training.

7. **Do you know of any other reasons why you should not do physical activity?**
   
   Significance/clarification:
   
   The exercise prescription may have to be modified in accordance with the specific reason provided.
Self-Assessment

Date:__________________

1. My exercise and physical activity goal is:

__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

2. I will make the following change(s) in order to achieve my goal:

__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

3. I am willing to do the following to make it happen:

__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

4. Others will know about the change I am making when:

__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

5. I might sabotage my plan by:

__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

6. Therefore, my agreement to myself is:

__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

7. Check-up dates:

__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

Signed:____________________________________________ __________

Support Person:____________________________________ ___________

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Dear Doctor:

Your Patient, ____________________________ wishes to start a personalized training program through the HSU Student Recreation Center. Exercise recommendations provided by the trainer will start easy and become progressively more intense depending on the client’s goal and fitness level.

If you know of any medical reasons why participation in the program by the client would be unwise please indicate so on this form.

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Report of Physician

☐ I know of no reason why the applicant may not participate

☐ I believe the client can participate, but I urge caution for the following reasons:
  ____________________________________________________
  ____________________________________________________

My patient is taking medications that will affect heart rate response to exercise. The effects of which are indicated below:

  Type of medication_________________________________
  Effect___________________________________________
  Exercise Restrictions______________________________

☐ The client should not engage in the following activities:________________________________________
  ____________________________________________________

☐ I recommend that the client NOT participate.

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Physician’s Name (please print) __________________________________________ Phone ____________________________

Physician’s Signature __________________________________________ Date __________

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