Personal Training Information and Pricing

Client 1 Name: _____________________  Client 2 Name: _______________ (if applicable)

Preferred Trainer: ___________________  Male ___  Female ___  No preference ___

Referred By: _______________________

What are your preferred workout times?

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>Preferred Times:</td>
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<td></td>
</tr>
</tbody>
</table>

Please circle/highlight one option:

**Services**

<table>
<thead>
<tr>
<th>Service</th>
<th>Students</th>
<th>SRC Member</th>
</tr>
</thead>
<tbody>
<tr>
<td>Body Fat Analysis</td>
<td>$5</td>
<td>$5</td>
</tr>
<tr>
<td>Fitness Assessment</td>
<td>$10</td>
<td>$20</td>
</tr>
<tr>
<td>Intro To Fitness</td>
<td>$50</td>
<td>$55</td>
</tr>
</tbody>
</table>

*Intro to Fitness* is a one-day two-hour comprehensive session that includes a Fitness Assessment, consultation, with a one Personal Training session, and a workout program.

**Single Sessions Packages***

<table>
<thead>
<tr>
<th>Package</th>
<th>Students</th>
<th>SRC Member</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single Session – 30 Minutes</td>
<td>$15</td>
<td>$17</td>
</tr>
<tr>
<td>Single Session – 1 hour</td>
<td>$30</td>
<td>$35</td>
</tr>
</tbody>
</table>

*Must have a Fitness Assessment prior to single sessions, Fitness Assessments are good for a year pending no health changes

**Individual Training Packages**

<table>
<thead>
<tr>
<th>Duration</th>
<th>Students</th>
<th>SRC Member</th>
</tr>
</thead>
<tbody>
<tr>
<td>30 Minutes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 sessions</td>
<td>$37.50</td>
<td>$41.25</td>
</tr>
<tr>
<td>6 sessions</td>
<td>$75</td>
<td>$82.50</td>
</tr>
<tr>
<td>15 sessions</td>
<td>$187.50</td>
<td>$206.25</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Duration</th>
<th>Students</th>
<th>SRC Member</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Hour Session</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 sessions</td>
<td>$70</td>
<td>$85</td>
</tr>
<tr>
<td>6 sessions</td>
<td>$135</td>
<td>$165</td>
</tr>
<tr>
<td>15 sessions</td>
<td>$300</td>
<td>$375</td>
</tr>
</tbody>
</table>

**1 Hour Partner Personal Training**

<table>
<thead>
<tr>
<th>Package</th>
<th>Students</th>
<th>SRC Member</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 sessions</td>
<td>$45*</td>
<td>$58*</td>
</tr>
<tr>
<td>6 sessions</td>
<td>$88*</td>
<td>$110*</td>
</tr>
</tbody>
</table>

*per person

**OFFICE USE ONLY**

DATE PAID Client 1: ______________  CHECK PACKAGE: (circle status)
DATE PAID Client 2: ______________  Student  SRC Member
Informed Consent for Participation in a Personal Training Program

- I hereby consent to voluntarily engage in a plan of personal training activities that are recommended to me for improvement of my general health and well being. The levels of exercise I perform will be based upon my cardiorespiratory and muscular fitness. I understand that I may be required to undergo a fitness assessment to evaluate my present level of fitness, and/or obtain physician consent to exercise. I will be given exact instructions regarding the amount and kind of exercise I should perform. I agree to participate in accordance with the personal trainer’s instruction. Trained, personal fitness trainers will provide leadership to direct my activities, monitor my performance, and evaluate my effort.

- If I am taking prescribed medications, I have already so informed the Assistant Director, Fitness/Fitness Coordinator, and will inform the Assistant Director, Fitness/Fitness Coordinator of any changes my doctor or I make with regard to the use of prescription drugs.

- I have been informed that during my participation in the personal training program, I will voluntarily complete the physical activities unless symptoms such as fatigue, shortness of breath, chest discomfort, or similar occurrences appear. At any point, I understand that it is my complete right to decrease or stop exercise, and it is my obligation to inform the personal trainer of my symptoms.

- I understand that during the performance of my personal training program, physical touching and/or positioning of my body may be necessary to assess my muscular and bodily reactions to specific exercises, and to ensure that I am using proper technique and body alignment. I expressly consent to physical contact for these reasons.

- I understand and have been informed that there exists the possibility of adverse changes and/or risk of bodily injury occurring during exercise including, but not limited to: abnormal blood pressure, fainting, dizziness, disorders of heart rhythm; in rare instances heart attack, stroke, or death; and injuries to muscles, ligaments, tendons, and joints. I have been told every effort will be made to minimize these occurrences by proper staff assessments of my condition before each exercise session, supervision during exercise, and by my own careful control of exercise efforts. I fully understand and accept the risks associated with exercise, including the risk of bodily injury, heart attack, stroke, or even death, but knowing these risks, it is my desire to participate as herein indicated.

- I understand that this program may benefit my physical fitness or general health, and if I follow the programs’ instructions, my exercise capacity and fitness level may improve after a period of 3 to 6 months. However, the program cannot guarantee any particular level of improvement. I recognize that involvement in the personal training sessions will allow me to learn proper ways to perform conditioning exercises, use fitness equipment, and regulate physical effort.

- I have been informed that the information obtained in this personal training program will be treated as privileged and confidential and will consequently not be released or revealed to any person without my express written consent except as required by law or the courts. I agree to the use of any information for the purpose of consultation with other health/fitness professionals, including my doctor. Any other information obtained will only be used by the program staff in the course of recommending exercise for me and evaluating my progress in the program.

- I have been given the opportunity to ask certain questions as to the procedures of this program. I understand that other risks may be associated with this personal training program. I agree to hold UNCG, its trustees, agents and employees harmless from any claims related to any injury or illness that may result from my participation.

- By signing below, I hereby irrevocably consent to the unrestricted use by The University of North Carolina at Greensboro or its advertisers, customers, agents, successors and assigns, of my name, portrait or picture for advertising purposes or purpose of trade. I voluntarily waive the right to inspect or approve such completed portraits, pictures or advertising matter used in connection therewith.

The privacy and confidentiality of your personal and health information is of paramount importance to us. Two federal acts, the Health Information Portability and Accountability Act 1996 better known as HIPAA and the Family Education Rights and Privacy Act or FERPA are the primary legal means protecting your rights to the privacy and confidentiality of your medical and educational records. In order to protect the confidentiality of your healthcare information, the Department of Campus Recreation will release or disclose information only with your signed authorization or as required or allowed by law. I understand that this release my also constitute a waiver of my privacy rights under The Federal Educational Rights and Privacy Act.

- I understand that all cancellations must be made a minimum of 24 hours prior to the scheduled training session. Cancellations can be made by calling your Personal Trainer or the Student Recreation Center at 336-334-5924/336-334-4030. If a cancellation is made less than 24 hours of the scheduled training session, I understand that I will be charged for one session.

Participant (Please Print) ____________________________________________________________________________
Participant (Signature) ____________________________________________________________________________
Date ____________________________________________________________________________________________

Assistant Director _______________________________________________________________________________
Date ____________________________________________________________________________________________

7/11/2014
Exercise-Readiness Screening Questionnaire

Please complete this form as accurately and thoroughly as possible. This information will be kept confidential by the fitness program employees. It will be used to ascertain whether it is prudent for you to obtain consent from your physician and/or whether a fitness assessment is indicated BEFORE beginning or increasing your exercise program. If you do not understand how to complete a specific question, please seek assistance.

Name__________________________________________________________________________
(Last) (First) (Middle Initial)
Date: _______________________ Email Address:________________________________________
Address: _____________________________________________________________________
________________________________________________________________________
Phone: (H)_____________(W)_____________ UNCG ID #: ________________________
Circle:      Male      Female
Date of Birth                Age_____
Circle one:  Freshman    Sophomore    Junior    Senior    Grad
           Faculty/Staff    Alumni    Spouse/Partner    Non-member

Medical/Surgical History

☐ Do you have any personal history of heart disease (coronary or atherosclerotic disease)?
☐ Any personal history of diabetes or other metabolic disease (thyroid, renal, liver)?
☐ Any personal history of pulmonary disease, asthma, interstitial lung disease or cystic fibrosis?
☐ Have you experienced pain or discomfort in your chest, neck, jaw, arms, or other areas apparently due to blood flow deficiency?
☐ Any unaccustomed shortness of breath (perhaps during light exercise)?
☐ Have you had any problems with dizziness or fainting?
☐ Do you have difficulty breathing while standing or sudden breathing problems at night?
☐ Have you experienced a rapid throbbing or fluttering of the heart?
☐ Have you experienced severe pain in leg muscles during walking?
☐ Do you suffer from ankle edema (swelling of the ankles)?
☐ Do you have a known heart murmur?
☐ Has your serum cholesterol been measured at greater than 200 mg/dl or LDL been measured greater than 130mg/dl or are you on lipid-lowering medication?
☐ Has your HDL (the "good" cholesterol) been measured at greater than 60 mg/dl?
☐ Have you had a high fasting blood glucose level on 2 or more occasions (>=100mg/dl)?
☐ Is your waist girth ratio greater than 40 inches (men) or 35 inches (women) or has a physician declared your BMI as greater than 30 kg/m²?
☐ Have you been assessed as hypertensive on at least 2 occasions (systolic > 140 mmHg or diastolic > 90mmHg)?
☐ Do you have any family history of heart attack, coronary surgery, or sudden death before 55 year of age in father or other first degree male relative or before 65 year of age in mother or other first degree female relative?
☐ Are you a current cigarette smoker or have you quit within the previous 6 months?

☐ Would you characterize your lifestyle as “sedentary” (Not participating in at least 30 minute of moderate intensity physical activity on at least three days of the week, for at least three months)?

**Physical Activity Readiness Questionnaire**

☐ Has your doctor ever said that you have a heart condition AND that you should only do physical activity recommended by a doctor?

☐ Do you feel pain in your chest when you do physical activity?

☐ In the past month, have you had chest pain when you were not doing physical activity?

☐ Do you lose your balance because of dizziness or do you ever lose consciousness?

☐ Do you have a bone or joint problem that could be made worse by a change in your physical activity?

☐ Is your doctor currently prescribing drugs (for example, water pills) for your blood pressure or heart condition?

☐ Do you know of any other reason why you should not do physical activity?

**Medical History/Information - Detail**

Please provide us with the following information:

Physician’s Name/Clinic __________________________________________

Phone Number __________________________________________

Fax Number __________________________________________

☐ Are you currently being treated for high blood pressure?

If you know your average blood pressure, please enter: _____ / _____

Please check all conditions or diagnoses that apply:

☐ Abnormal EKG? ☐ Limited Range of Motion? ☐ Stroke?

☐ Abnormal Chest X-Ray? ☐ Arthritis? ☐ Epilepsy or Seizures?

☐ Rheumatic Fever? ☐ Bursitis? ☐ Chronic Headaches or Migraines?

☐ Low Blood Pressure? ☐ Swollen or Painful Joints? ☐ Persistent Fatigue?

☐ Asthma? ☐ Foot Problems? ☐ Stomach Problems?

☐ Bronchitis? ☐ Knee Problems? ☐ Hernia?

☐ Emphysema? ☐ Back Problems? ☐ Anemia?

☐ Other Lung Problems? ☐ Shoulder Problems? ☐ Are You Pregnant?

☐ Recently Broken Bones?

☐ Has a doctor imposed any activity restrictions? If so, please describe:

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

2
Family History
Have your mother, father, or siblings suffered from (please select all that apply):

- Congenital heart disease
- Hypertension
- Diabetes
- Heart Attack
- Obesity
- Asthma
- Osteoporosis
- High Cholesterol
- Left ventricular hypertrophy
- Stroke
- Hypertension
- Diabetes
- Heart Attack
- Asthma
- Osteoporosis
- High Cholesterol
- Left ventricular hypertrophy
- Stroke

Medications
Please select any medications you are currently using:

- Diuretics
- Beta Blockers
- Vasodilators
- Alpha Blockers
- Calcium Channel Blockers
- Other Cardiovascular
- NSAIDS/Anti-inflammatory (Motrin, Advil)
- Cholesterol
- Diabetes/Insulin
- Other Drugs (record below).

Please list the specific medications/supplements that you currently take:
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

1) Do you experience sudden tingling, numbness, or loss of feeling in your arms, hands, legs, feet, or face?
   Yes  No

2) Have you ever noticed your hands and feet feel cooler than the rest of your body?
   Yes  No

3) Do you get pains and/or cramps in your legs?
   Yes  No

4) When was the last time you had a physical examination? Date: ____________________

5) Please list your last three hospitalizations:
   1  2  3

Type of operation: ____________________ ____________________ ____________________

Date: ____________________ ____________________ ____________________

*Adapted from the American College of Sports Medicine’s Health/Fitness Standards & Guidelines