CONGRATULATIONS

By deciding to invest in a one-on-one consultation, you have taken another step forward in improving your current fitness level. Each session will be packed with education, exercise and expertise designed to meet your health needs! All information provided here in will be kept confidential.

Please follow these simple steps to make your first appointment go smoothly:

1. Please fill out the pertinent information for your selected consultation and return it to the Fitness Center front desk to schedule your appointment. This allows our staff to review the material prior to your session.

2. Come appropriately dressed to work out and remember to bring water. Please no jeans or open toed shoes.

3. Please be on time or even a bit early so that we have the entire session to meet or work out.

4. Meet your trainer/consultant on the third floor outside the entrance of the fitness center.

5. If you cannot make an appointment, please notify your trainer directly. We have taken special care to reserve these time slots for you. If you do not show up or call, we are unable to utilize this time to consult with another member.

CR | Ole Miss CAMPUS RECREATION

Physical Activity Readiness
Questionnaire - PAR-Q
(revised 2002)

PAR-Q & YOU

(A Questionnaire for People Aged 15 to 69)

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 seven questions in the box below. If you are between the ages of 15 and 69, the PAR-Q will tell you if you should check with your doctor before you start. If you are over 69 years of age, and you are not used to being very active, check with your doctor.

Common sense is your best guide when you answer these questions. Please read the questions carefully and answer each one honestly: check YES or NO.

YES	NO		
☐	☐	1.	**Has your doctor ever said that you have a heart condition and that you should only do physical activity recommended by a doctor?**
☐	☐	2.	**Do you feel pain in your chest when you do physical activity?**
☐	☐	3.	**In the past month, have you had chest pain when you were not doing physical activity?**
☐	☐	4.	**Do you lose your balance because of dizziness or do you ever lose consciousness?**
☐	☐	5.	**Do you have a bone or joint problem (for example, back, knee or hip) that could be made worse by a change in your physical activity?**
☐	☐	6.	**Is your doctor currently prescribing drugs (for example, water pills) for your blood pressure or heart condition?**
☐	☐	7.	**Do you know of any other reason why you should not do physical activity?**

If you answered

YES to one or more questions

Talk with your doctor by phone or in person BEFORE you start becoming much more physically active or BEFORE you have a fitness appraisal. Tell your doctor about the PAR-Q and which questions you answered YES.

- 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.
- Find out which community programs are safe and helpful for you.

NO to all questions

If you answered NO honestly to all PAR-Q questions, you can be reasonably sure that you can:

- start becoming much more physically active – begin slowly and build up gradually. This is the safest and easiest way to go.
- take part in a fitness appraisal – this is an excellent way to determine your basic fitness so that you can plan the best way for you to live actively. It is also highly recommended that you have your blood pressure evaluated. If your reading is over 144/94, talk with your doctor before you start becoming much more physically active.

DELAY BECOMING MUCH MORE ACTIVE:

- if you are not feeling well because of a temporary illness such as a cold or a fever – wait until you feel better; or
- if you are or may be pregnant – talk to your doctor before you start becoming more active.

PLEASE NOTE: If your health changes so that you then answer YES to any of the above questions, tell your fitness or health professional. Ask whether you should change your physical activity plan.

Informed Use of the PAR-Q: The Canadian Society for Exercise Physiology, Health Canada, and their agents assume no liability for persons who undertake physical activity, and if in doubt after completing this questionnaire, consult your doctor prior to physical activity.

No changes permitted. You are encouraged to photocopy the PAR-Q but only if you use the entire form.

NOTE: If the PAR-Q is being given to a person before he or she participates in a physical activity program or a fitness appraisal, this section may be used for legal or administrative purposes.

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

NAME _____

SIGNATURE _____ DATE _____

SIGNATURE OF PARENT or GUARDIAN (for participants under the age of majority) _____ WITNESS _____

Note: This physical activity clearance is valid for a maximum of 12 months from the date it is completed and becomes invalid if your condition changes so that you would answer YES to any of the seven questions.

Supported by: Health Canada Santé Canada

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Turner Fitness Center Health History Questionnaire

Personal Information

Name: (Last)_____(First)_____(MI)_____

Address: Street_____ Apt.#_____

City_____ State_____Zip_____

E-Mail Address:_____

Telephone: Home (_____) _____-_____ Work (_____)_____-_____

Date of Birth:_____/_____/_____ Age:_____ Gender:_____

Personal Medical History

Past Operations:

_____

_____

Hospitalizations:

_____

_____

Disabilities:_____

Diseases:_____

Are you currently under a physicians care?_____yes _____no

If yes, explain:_____

Length of time since last check-up:_____

Physician:_____ Phone#: (____)_____-_____
Fax#: (____)_____-_____

*Your physician may be contacted for consent to begin an exercise program if needed.

Height:_____ Weight_____ Desired Weight:_____

Personal Medical Information

Please list any medications taken regularly and the reason for taking it:

1._____

2._____

3._____

4._____

Are any of these medications classified as a Beta Blocker? _____Yes _____No
Are you allergic to any medications? _____Yes _____No
If yes, please specify:_____

PLEASE INDICATE IF YOU HAVE A PERSONAL HISTORY OF ANY OF THE FOLLOWING:

During the past 12 months, has your weight fluctuated more than a few pounds? No Yes
Heart Disease/Surgery: No Yes
If yes, explain:_____
Heart Murmur: No Yes Explain_____
Enlarged Heart: No Yes Explain_____
Irregular Heartbeat: No Yes Explain_____
Chest Pain with Exertion: No Yes Explain_____
Stroke: No Yes Explain_____
Peripheral Vascular Disease: No Yes Explain_____
Physical Exam in past 5 years: No Yes Explain_____
Epilepsy: No Yes Explain_____
Varicose Veins: No Yes Explain_____
Blood Clots: No Yes Explain_____
High Blood Pressure: No Yes Explain_____
Resting Systolic:_____
Resting Diastolic:_____
Elevated Cholesterol: No Yes Explain_____
Level:_____
Elevated Triglycerides: No Yes Explain_____
Resting Heart Rate:_____
EKG: _____Never Taken _____Normal _____Abnormal
If abnormal, explain:_____
Stress Test: _____Never Taken _____Normal _____Abnormal
If abnormal, explain:_____
Recent Surgery: No Yes Explain_____
_____

Light-headedness: No Yes Explain_____
Fainting: No Yes Explain_____
Fatigue: No Yes Explain_____
Shortness of Breath: No Yes Explain_____
Asthma: No Yes Explain_____
Exercise-induced Asthma: No Yes Explain_____
Rheumatic Fever: No Yes Explain_____
Hernia: No Yes Explain_____
Anemia: No Yes Explain_____
Diagnosed Hypoglycemia: No Yes Explain_____
Diabetes: No Yes
If yes, list type:_____
Obesity: No Yes Explain_____
Anorexia: No Yes Explain_____
Bulimia: No Yes Explain_____
Severe Headaches: No Yes Explain_____
Insomnia: No Yes Explain_____
Chronic Morning Cough: No Yes Explain_____
Kidney Failure: No Yes Explain_____
Kidney Removal: No Yes Explain_____
Kidney Stones: No Yes Explain_____
Kidney Dialysis: No Yes Explain_____
Gout: No Yes Explain_____
Gall Bladder Removal: No Yes Explain_____
Gall Bladder Disease/Stones: No Yes Explain_____
Colitis: No Yes Explain_____
Arthritis: No Yes
If yes, what parts of the body are affected:_____
Sickle Cell Trait: No Yes Explain_____
Back Pain/Sciatica: No Yes Explain_____
Shoulder Pain/Injury: No Yes Explain_____
Arm/Elbow Injury/Pain: No Yes Explain_____
Tennis Elbow: No Yes Explain_____
Wrist/Hand Injury or Pain: No Yes Explain_____
Calcium Deposits: No Yes Explain_____
Fibromyalgia: No Yes Explain_____
Swelling in Feet or Ankles: No Yes Explain_____
Ankle/Foot Pain or Injury: No Yes Explain_____
Achilles Pain: No Yes Explain_____
Shin Splints: No Yes Explain_____
Knee Injury or Pain: No Yes Explain_____
Hip Injury/Pain: No Yes Explain_____
Nerve Damage: No Yes Explain_____
Numbness/Tingling in Limbs: No Yes

If yes, what limbs are affected:_____

Head/Neck Injury or Pain: No Yes Explain_____

Bone Fracture: No Yes

If yes, where:_____

Cancer: No Yes

If yes, please explain:_____

Smoker: No Yes

If yes, how long/number per day/time since quiting:_____

Please rate your current activity level:_____Low _____Moderate _____Active

Please Rate the Stress Level of your job:_____Low _____Moderate _____High

When exercising, do you experience any of the following?:

_____Chest Pains _____Leg Aches _____ Fatigue/Tiredness

_____Pressure over Heart _____Shortness of Breath _____Dizziness

Please complete ONLY if you are or are attempting to become pregnant:

Planning to become pregnant: No Yes

If yes, when:_____

Pre-pregnancy weight:_____

Planning to breast-feed: No Yes

Currently breast-feeding: No Yes

Family Medical History:

Please list family members affected, age of onset, type and actions taken for the following:

Heart Disease: No Yes Explain_____

High Blood Pressure: No Yes Explain_____

Elevated Cholesterol: No Yes Explain_____

Diabetes: No Yes Explain_____

Cancer: No Yes Explain_____

Stroke: No Yes Explain_____

Obesity: No Yes Explain_____

Any additional comments or information before you begin your exercise program:

Personal Fitness Evaluation

Please fill out this form thoroughly and completely. If you have any questions, feel free to ask our staff for assistance. Please be as honest as possible in your responses.

1. Do you have any negative feelings toward or have you had any bad experiences with physical activity programs?

2. Do you have any negative feelings toward or have you had any bad experiences with fitness testing and evaluation?

3. Rate yourself on a scale of 1 to 5, with 1 indicating the lowest value and 5 the highest. Circle the most applicable to you.

Characterize your present athletic ability:
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 level of flexibility:
1 2 3 4 5

4. Are you currently involved in regular exercise?

_____Yes _____No If yes, what type of exercise:_____

5. What types of activities interest you?

6. Do you enjoy participating in activities alone or in a group?

7. What barriers do you think have prevented you in the past from beginning or adhering to an exercise program?

Rank your goals in undertaking exercise from 1 to 10, with 1 being the most important to you.

_____Improve cardiovascular fitness
_____Reduce body fat level
_____Reshape or tone my body
_____Improve flexibility
_____Lose weight
_____Gain Weight
_____Enjoyment
_____Increase strength
_____Increase energy level
_____Other (please explain)

Understanding of Participation
Informed Consent and Release of Liability

Release

I the undersigned, realizing that there is inherent risk in any recreational activity, and in consideration of my being allowed to participate in this event, personally assume all risk in connection with any activity in the Turner Fitness Center or activity sponsored by the Turner Fitness Center. I further agree to release and hold harmless the State of Mississippi, The University of Mississippi, their Board of Trustees, their officers, agents, and employees from any and all claims and liabilities of any type whatsoever, and for damages to loss or destruction of any property, or injury, sickness or death, which may now or hereafter arise. (*Initial* _____)

Health Insurance Responsibility

I understand that it is my responsibility to obtain health insurance and not the responsibility of the State of Mississippi or any of its agencies, including the University of Mississippi. I voluntarily waive any and all claims, both present and future, that may be made by me, my family, estate, heirs, or assigns against the University and/or Board. I further state that I am of lawful age and legally competent to sign this release; that I understand the terms herein is contractual and not a mere recital; and that I have signed this document of my own free will. (*Initial* _____)

Physical Ability to Participate

I do hereby further declare that I am physically able to participate in a variety of physical activities including but not limited to, cardiovascular exercise such as step aerobics, kickboxing, running, biking, elliptical training, swimming, dancing; strength training and flexibility exercises such as weight training, yoga, stretching, and I have no physical impairment, disease, illness, or condition that would prevent me from safe participation. (*Initial* _____)

Potential Risks

I understand that injury including but not limited to, heart attack, muscle strain, pull or tear, broken bones, shin splints, heat prostration, knee/lower back/foot injuries, muscle soreness and even death is possible by participating in a fitness program. I acknowledge I have been advised that I should have yearly or more frequent physical examinations, and I either have a physical examination and my physician's approval before engaging in physical activity, or I choose to participate without my physician's approval and hereby assume all responsibility for my participation and activities in a fitness program. (*Initial* _____)

Printed Name: _____

Signature of Participant: _____ Date: _____

Witness: _____ Date: _____

Personal Training Contract

Name _____ Phone_____ Email_____

Membership Status (Circle One) Student Faculty/Staff F/S Family Community

Emergency Contact _____ Phone_____
Relationship to You _____.

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INDIVIDUAL PACKAGE OPTIONS

_____5 sessions	$75	_____20 sessions	$300
_____8 sessions	$120	_____24 sessions	$350
_____12 sessions	$180	_____28 sessions	$400
_____16 sessions	$240	_____32 sessions	$450

PARTNER PACKAGES	COST	COST/PERSON
_____8 sessions	$192	$12.00/session/person
_____12 sessions	$276	$11.50/session/person
_____16 sessions	$360	$11.25/session/person

All packages begin with a fitness assessment and consultation.
Sessions are one hour in length.

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PERSONAL TRAINING POLICIES

Package Completion Policy: Participants have 150 days from the date of the first session to complete all sessions purchased. Failure to do so will result in the forfeiture of the remaining sessions.

Individual Session Cancellation Policy: Individual sessions must be cancelled at least 24 hours before your scheduled training time. Failure to cancel or to show up for a scheduled session will result in the loss of your training session. Please contact your trainer directly to cancel a session. Thank you for your cooperation.

Package Cancellation/Refund Policy: To cancel the remaining sessions of a purchased package and receive a refund in the amount of the unused sessions, the participant **MUST** produce the original receipt given when payment is accepted. No exceptions.

Participant Signature: _____

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PLEASE LIST ALL AVAILABILITY FOR TRAINING

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

**Once all availability is listed, please highlight/designate your preferred training days/times

_____If possible, I would prefer a Male/Female Trainer. Preferred Trainer's Name:_____

OR

_____I have no preference in trainers.

_____I was referred to this program by a previous patron.
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