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.
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.

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
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<tbody>
<tr>
<td></td>
<td>1. Has your doctor ever said that you have a heart condition and that you should only do physical activity recommended by a doctor?</td>
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<td>2. Do you feel pain in your chest when you do physical activity?</td>
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<td>3. In the past month, have you had chest pain when you were not doing physical activity?</td>
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<td>4. Do you lose your balance because of dizziness or do you ever lose consciousness?</td>
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<td>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?</td>
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<td></td>
<td>6. Is your doctor currently prescribing drugs (for example, water pills) for your blood pressure or heart condition?</td>
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<tr>
<td></td>
<td>7. Do you know of any other reason why you should not do physical activity?</td>
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</tbody>
</table>

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.

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.

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: 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.
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 ______

Enlarged Heart: No ______ Yes ______

Irregular Heartbeat: No ______ Yes ______

Chest Pain with Exertion: No ______ Yes ______

Stroke: No ______ Yes ______

Peripheral Vascular Disease: No ______ Yes ______

Physical Exam in past 5 years: No ______ Yes ______

Epilepsy: No ______ Yes ______

Varicose Veins: No ______ Yes ______

Blood Clots: No ______ Yes ______

High Blood Pressure: No ______ Yes ______

  Resting Systolic: __________
  Resting Diastolic: __________

Elevated Cholesterol: No ______ Yes ______

Level: ______________________

Elevated Triglycerides: No ______ Yes ______

Resting Heart Rate: __________

**EKG:** ______ Never Taken ______ Normal ______ Abnormal

If abnormal, explain: _______________________________________________________  

**Stress Test:** ______ Never Taken ______ Normal ______ Abnormal

If abnormal, explain: _______________________________________________________  

**Recent Surgery:** No ______ Yes ______

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<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes</th>
<th>No</th>
<th>Explain</th>
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</thead>
<tbody>
<tr>
<td>Light-headedness</td>
<td></td>
<td>Yes</td>
<td></td>
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<tr>
<td>Fainting</td>
<td></td>
<td>Yes</td>
<td></td>
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<tr>
<td>Fatigue</td>
<td></td>
<td>Yes</td>
<td></td>
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<tr>
<td>Shortness of Breath</td>
<td></td>
<td>Yes</td>
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<tr>
<td>Asthma</td>
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<td>Yes</td>
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<tr>
<td>Exercise-induced Asthma</td>
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<td>Yes</td>
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<tr>
<td>Rheumatic Fever</td>
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<td>Yes</td>
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<tr>
<td>Hernia</td>
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<td>Yes</td>
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<tr>
<td>Anemia</td>
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<td>Yes</td>
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<tr>
<td>Diagnosed Hypoglycemia</td>
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<td>Yes</td>
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<tr>
<td>Diabetes</td>
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<td>Yes</td>
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<tr>
<td>Obesity</td>
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<td>Yes</td>
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<tr>
<td>Anorexia</td>
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<td>Yes</td>
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<tr>
<td>Bulimia</td>
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<td>Yes</td>
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<tr>
<td>Severe Headaches</td>
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<td>Yes</td>
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<tr>
<td>Insomnia</td>
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<td>Yes</td>
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<tr>
<td>Chronic Morning Cough</td>
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<td>Kidney Failure</td>
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<tr>
<td>Kidney Removal</td>
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<td>Yes</td>
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<tr>
<td>Kidney Stones</td>
<td></td>
<td>Yes</td>
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<tr>
<td>Kidney Dialysis</td>
<td></td>
<td>Yes</td>
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<tr>
<td>Gout</td>
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<td>Yes</td>
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<tr>
<td>Gall Bladder Removal</td>
<td></td>
<td>Yes</td>
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<tr>
<td>Gall Bladder Disease/Stones</td>
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<td>Yes</td>
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<tr>
<td>Colitis</td>
<td></td>
<td>Yes</td>
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<tr>
<td>Arthritis</td>
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<td>Yes</td>
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<tr>
<td>Sickle Cell Trait</td>
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<td>Yes</td>
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<tr>
<td>Back Pain/Sciatica</td>
<td></td>
<td>Yes</td>
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<tr>
<td>Shoulder Pain/Injury</td>
<td></td>
<td>Yes</td>
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<tr>
<td>Arm/Elbow Injury/Pain</td>
<td></td>
<td>Yes</td>
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<tr>
<td>Tennis Elbow</td>
<td></td>
<td>Yes</td>
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<tr>
<td>Wrist/Hand Injury or Pain</td>
<td></td>
<td>Yes</td>
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<tr>
<td>Calcium Deposits</td>
<td></td>
<td>Yes</td>
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<tr>
<td>Fibromyalgia</td>
<td></td>
<td>Yes</td>
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<tr>
<td>Swelling in Feet or Ankles</td>
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<tr>
<td>Ankle/Foot Pain or Injury</td>
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<td>Yes</td>
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<tr>
<td>Achilles Pain</td>
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<td>Yes</td>
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<tr>
<td>Shin Splints</td>
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<td>Yes</td>
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<tr>
<td>Knee Injury or Pain</td>
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<td>Yes</td>
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<tr>
<td>Hip Injury/Pain</td>
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<td>Yes</td>
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<tr>
<td>Nerve Damage</td>
<td></td>
<td>Yes</td>
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</tr>
<tr>
<td>Numbness/Tingling in Limbs</td>
<td></td>
<td>Yes</td>
<td></td>
</tr>
</tbody>
</table>
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  ____Gain Weight
_____Reduce body fat level  ____Enjoyment
_____Reshape or tone my body  ____Increase strength
_____Improve flexibility  ____Increase energy level
_____Lose weight  ____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 __________________________ Phone __________________________

~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~

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.

~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~

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: ________________________________ ________________________________

PLEASE LIST ALL AVAILABILITY FOR TRAINING

<table>
<thead>
<tr>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
<th>Saturday</th>
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**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.