

Fitness Training Client/Trainer Agreement

Policies and Procedures

1. Sessions last at least 50 minutes but do not exceed 60 minutes. Please be ready to begin at your scheduled time. Personal trainers are expected to wait 15 minutes for a client at which time it is their discretion whether to keep the appointment. Clients will be charged for the entire session regardless of the actual duration.
2. Cancellations
 - A) Upon each individual trainer's discretion you may or may not receive credit for any workout unless **it was cancelled with at least 24 hours advance notification**. Cancellations must be verified by calling your respective trainer's phone number and speaking directly to him/her or leaving a message in his/her voice mailbox.
 - B) If you receive credit for cancelled workouts, you must use these credits within 60 days or credit will be lost.
 - C) If you have cancelled three or more sessions the trainer has the right to decline renewing your next set of sessions.
- 3) No Shows
 - A) A "no show/no call" is a session where the client is scheduled for a mutually agreed upon session but does not show up and does not call 24 hours in advance for rescheduling.
 - B) A "no show/no call" will not be refunded/credited or rescheduled.
 - C) If you have 3 or more "no show/no call" sessions the trainer has the right to decline renewing your next set of sessions.
- 4) Payment
 - A) Payment for all fitness training services must be made at the Reception Desk of the URecFit at the SMC Campus Center. At no time should there be any currency exchange between the client and trainer for payment of fitness training services.
 - B) Payment is due in advance of the first session. Thereafter, you must have credit for at least one session or you will not be trained (ex., if you purchase 10 sessions, at the end of your 10th session you must purchase another package before you can be trained again).
 - C) After payment, submit your receipt to your trainer for him/her to place in your chart. If you would like a receipt for your own records you may ask the front office staff to print you another receipt.
 - D) If a check is returned, training will be immediately terminated.
- 5) There is a 6 month expiration date from the date of purchase for all fitness training packages not including university scheduled vacations.
- 6) In the event your trainer is more than 10 minutes late or fails to attend a scheduled appointment, the remaining, or the following session is free.
- 7) Clients are required to observe all rules of the URecFit - Fitness Center.
- 8) A water bottle is required during all sessions.
- 9) Clients have the right to terminate a particular exercise or workout at any time (without refund).

You are in control of your workouts. If any exercise is uncomfortable or painful, or if you want to stop for any reason, you may do so.

Client's Signature: _____ **Date:** _____

You will get from your workouts what you put in. You are the only one who can make sure you work out consistently, eat properly, rest enough, and live a healthy lifestyle.

Health History

CLIENT INFORMATION

First Name _____ Last Name _____ Date _____

Age _____ Date of Birth ____/____/____ Gender _____

Type of Membership: Student Faculty/Staff Other: _____

Address _____ Preferred Phone Number _____

Email _____

Physician's Name _____ Physician's Number _____

PERSONAL MEDICAL HISTORY

Have you had any past operations, hospitalizations, disabilities, diseases or are you currently under a physician's care:

Height _____ Weight _____ Desired Weight _____

Have you ever been diagnosed with the following? Please check all that apply and write the date and a description below.

Date and Description

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Seizure/epilepsy | <input type="checkbox"/> Stroke | <input type="checkbox"/> High Blood Triglycerides |
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Exercise-induced Asthma |
| <input type="checkbox"/> Thyroid Disorders | <input type="checkbox"/> Allergies | <input type="checkbox"/> Varicose Veins | <input type="checkbox"/> Hernia |
| <input type="checkbox"/> Obesity | <input type="checkbox"/> Anorexia | <input type="checkbox"/> Bulimia | <input type="checkbox"/> Severe Headaches |
| <input type="checkbox"/> Kidney Failure | <input type="checkbox"/> Kidney Removal | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Kidney Dialysis |
| <input type="checkbox"/> Colitis | <input type="checkbox"/> Gall Bladder Removal | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Gall Bladder Disease/stones | | |
-
-
-
-

SYMPTOMS REVIEW

Have you ever experienced the following during exercise, after exercise or during a resting state? Please check all that apply.

- | | | |
|--|--|---|
| <input type="checkbox"/> Shortness of breath or wheezing | <input type="checkbox"/> Side aches or side stitches | <input type="checkbox"/> Middle back pain |
| <input type="checkbox"/> Extremely high heart rate | <input type="checkbox"/> Irregular heart rate | <input type="checkbox"/> Shoulder pain |
| <input type="checkbox"/> Sharp Chest Pain | <input type="checkbox"/> Dull aching chest pain | <input type="checkbox"/> Foot or ankle pain |
| <input type="checkbox"/> Overall or one-sided weakness | <input type="checkbox"/> Loss of coordination | <input type="checkbox"/> Knee pain |
| <input type="checkbox"/> Heat intolerance | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Low Back pain |
| <input type="checkbox"/> Mental Confusion | <input type="checkbox"/> Fainting | <input type="checkbox"/> Calf pain |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Swelling of ankles or hands | <input type="checkbox"/> Hip pain/sciatica |
| <input type="checkbox"/> Cramping | <input type="checkbox"/> Shin Splints | <input type="checkbox"/> Arm or neck pain |

MEDICATIONS

Please check all that apply and describe side effects

- Digitalis
- Anti-arrhythmias
- Diuretics and Electrolytes
- Metabolics
- Beta Blockers
- Tranquilizers or sedatives
- Vasodilators
- Alpha Blockers
- Calcium Channel Blockers
- Other
- Anti-inflammatory (Motrin, Advil)

INJURY HISTORY

Have you ever suffered an injury at any of the following joints? If yes, please describe severity and frequency.

Ankle (R or L)

Knee (R or L)

Hips

Low Back

Shoulder (R or L)

Neck

Other

Do any of the joints above bother you during exercise? Yes, please explain below No

FAMILY HISTORY

Please check if anyone in your immediate family (grandparents, parent, and siblings) experienced any of the following.

	Relationship	Age	Description
<input type="checkbox"/> Heart Attack or stroke before age of 55	_____	_____	_____
<input type="checkbox"/> Heart Surgery	_____	_____	_____
<input type="checkbox"/> High Cholesterol	_____	_____	_____
<input type="checkbox"/> High Blood Pressure	_____	_____	_____
<input type="checkbox"/> High Blood Triglycerides	_____	_____	_____
<input type="checkbox"/> Diabetes	_____	_____	_____
<input type="checkbox"/> Cancer	_____	_____	_____
<input type="checkbox"/> Alzheimer's	_____	_____	_____
<input type="checkbox"/> Heart Operations	_____	_____	_____
<input type="checkbox"/> Congenital Heart Disease	_____	_____	_____
<input type="checkbox"/> Early death	_____	_____	_____
<input type="checkbox"/> Other family illness	_____	_____	_____

LIFE STYLE QUESTIONNAIRE

Please check all that apply.

Do you smoke?

- No Yes

If you checked yes please select from the following

- Cigarettes Cigar Pipe

If you checked any of the following, how many do you smoke a day? _____

If you checked any of the following, how many years have you smoked? _____

Former Smoker

If you checked the following, how long ago did you stop smoking? _____

Do you drink alcoholic beverages? Yes No

If you checked yes to the above question, how much do you drink (in ounces) in an average week? _____

LIFE STYLE QUESTIONNAIRE continued...

Do you drink caffeinated beverages? Yes No

If you checked yes to the above question, how many cups a day? _____

Please rate your Daily Stress Levels (select one)

- Low Moderate High-but I enjoy the challenge
 High-sometimes difficult to handle High-often difficult to handle

Please describe your quality of sleep and or any unusual sleep patterns:

Describe what you eat on a typical day, give specific examples. (**Give an approximate time of when you eat each**)

Breakfast _____

Lunch _____

Dinner _____

Other _____

Recent Exercise Habits

How many times per week are you physically active? _____

When you are physically active, how long does it last? _____

On a scale from 1 to 10, how intense is your typical activity? (10 being highest) _____

How many years have you been exercising? _____

In a typical week, how many minutes do you spend in the following activities?

Running/jogging: _____

Walking: _____

Aerobics: _____

Racquet Sports: _____

Swimming: _____

Weight Training: _____

Biking: _____

Skiing: _____

Stair Climbing: _____

Yoga: _____

Pilates: _____

Other:

PREFERENCES

What is your gender preference for your Fitness Trainer? Either Male Female

Do you wish to request a specific Fitness Trainer? If so please name here: _____

Please indicate what days would be good for you to work with the RYT:

Monday Tuesday Wednesday Thursday Friday Saturday Sunday

Please list times on the days you choose that would work best for you.

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 please complete a Physician's Clearance form before becoming more active.

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?

YES to one or more questions

If
you
answered

Complete a physician's clearance BEFORE you start becoming much more physically active or BEFORE you have a fitness assessment. 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 physician 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 gradually 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 University of Maryland, Baltimore, SMC Campus Center and University Recreation and Fitness Services 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. Note: If the PAR-Q is being given to a person before he or she participates in a physical activity program or 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: _____ Date: _____

Signature: _____

Physician's Statement and Clearance Form

Licensed Medical Physician's clearance to participate in a progressive exercise program is requested for:

Client's Name: _____ Physician's Name: _____

Date of Birth: _____ Physician's Phone: _____

The University of Maryland Fitness Training Program provides a variety of fitness opportunities for the University community. These activities may be vigorous in nature and are usually challenging to the individual's cardio respiratory and muscular systems. The individual may be involved in a class, personal training and/or self directed type of exercise program.

It is my understanding that _____ will be participating in a flexibility/fitness evaluation and/or exercise program. I understand that the aspects of the program will include the following.	
1	Physiological tests including: 1. Resting heart rate and blood pressure 2. Body composition (skin folds) 3. Abdominal Strength: Curl-ups and Push-ups 4. Cardiovascular testing 5. Flexibility 6. Other: _____
2	Exercise program including: 1. Strength training using body weight, bands, etc. 2. Cardiovascular Training 3. Other: _____

Please list any recommendations or restrictions that are appropriate for your patient in this exercise program:

As the individual's attending physician, I am not aware of any medical condition that would prevent him/her from participation in the exercise outlined above.

Physician's Signature _____

Date _____ Phone _____

Thank you for taking the time to fill this out. Please return the form to: UM URecFit

Jimmy Mszanski
Assistant Director – Fitness
621 W Lombard St, Room 509
Phone: (410) 706-5355 Fax: (410) 706-1472