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 Business Desk at URecFit and Wellness at the SMC Campus Center or on the URecFit Live Portal. 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.

<table>
<thead>
<tr>
<th>Date and Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Heart Attack □ High Blood Pressure □ High Cholesterol □ Rheumatic Fever</td>
</tr>
<tr>
<td>□ Heart Murmur □ Seizure/epilepsy □ Stroke □ High Blood Triglycerides</td>
</tr>
<tr>
<td>□ Blood Clots □ Cancer □ Diabetes □ Asthma</td>
</tr>
<tr>
<td>□ Gout □ Arthritis □ Osteoporosis □ Exercise-induced Asthma</td>
</tr>
<tr>
<td>□ Thyroid Disorders □ Allergies □ Varicose Veins □ Hernia</td>
</tr>
<tr>
<td>□ Obesity □ Anorexia □ Bulimia □ Severe Headaches</td>
</tr>
<tr>
<td>□ Kidney Failure □ Kidney Removal □ Kidney Stones □ Kidney Dialysis</td>
</tr>
<tr>
<td>□ Colitis □ Gall Bladder Removal □ Fibromyalgia □ Anemia</td>
</tr>
<tr>
<td>□ Pregnancy □ Gall Bladder Disease/stones</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>SYMPTOMS REVIEW</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have you ever experienced the following during exercise, after exercise or during a resting state? Please check all that apply.</td>
</tr>
<tr>
<td>□ Shortness of breath or wheezing □ Side aches or side stitches □ Middle back pain</td>
</tr>
<tr>
<td>□ Extremely high heart rate □ Irregular heart rate □ Shoulder pain</td>
</tr>
<tr>
<td>□ Sharp Chest Pain □ Dull aching chest pain □ Foot or ankle pain</td>
</tr>
<tr>
<td>□ Overall or one-sided weakness □ Loss of coordination □ Knee pain</td>
</tr>
<tr>
<td>□ Heat intolerance □ Dizziness □ Low Back pain</td>
</tr>
<tr>
<td>□ Mental Confusion □ Fainting □ Calf pain</td>
</tr>
<tr>
<td>□ Vomiting □ Swelling of ankles or hands □ Hip pain/sciatica</td>
</tr>
<tr>
<td>□ Cramping □ Shin Splints □ Arm or neck pain</td>
</tr>
</tbody>
</table>
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.

<table>
<thead>
<tr>
<th>Relationship</th>
<th>Age</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart Attack or stroke before age of 55</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart Surgery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>High Cholesterol</td>
<td></td>
<td></td>
</tr>
<tr>
<td>High Blood Pressure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>High Blood Triglycerides</td>
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</tr>
<tr>
<td>Diabetes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cancer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alzheimer’s</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart Operations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Congenital Heart Disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Early death</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other family illness</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<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>
<td></td>
</tr>
<tr>
<td>2. Do you feel pain in your chest when you do physical activity?</td>
<td></td>
</tr>
<tr>
<td>3. 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>4. Do you lose your balance because of dizziness or do you ever lose consciousness?</td>
<td></td>
</tr>
<tr>
<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>
<td></td>
</tr>
<tr>
<td>6. Is your doctor currently prescribing drugs (for example, water pills) for your blood pressure or heart condition?</td>
<td></td>
</tr>
<tr>
<td>7. Do you know of any other reason why you should not do physical activity?</td>
<td></td>
</tr>
</tbody>
</table>

If you answered YES to one or more questions

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.

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