

Session I Deadline: Friday, August 26th by 9:00 am
Session II Deadline: Friday, October 7th by 9:00 am



CLIENT PRE-EVALUATION
DHFS WELLNESS PROGRAM
5-WEEK PERSONAL TRAINING PROGRAM
(SEE INFO ON BOTTOM OF BACK PAGE)

TODAY'S DATE _____

NAME _____ GENDER _____ AGE _____

DEPARTMENT _____

WHEN IS THE BEST TIME(S) FOR THE TRAINER TO CONTACT YOU? _____

PHONE NUMBER(S) WHERE YOU CAN BE REACHED _____

EMAIL _____

CHOOSE THE PREFERRED LOCATION TO MEET WITH YOUR TRAINER:

KIN Exercise Room JES Exercise Room

AFTER YOU ARE MATCHED WITH A TRAINER, S/HE WILL CONTACT YOU TO SET UP APPOINTMENTS. ALL 5 SESSIONS MUST BE SCHEDULED AND AGREED TO AT THE START OF THE 5 WEEKS SINCE STUDENT TRAINERS WILL BE GRADED AND EVALUATED THROUGHOUT. CANCELLATIONS ARE ALLOWED ONLY FOR TRUE EMERGENCIES; FAILURE TO COMPLY WILL RESULT IN REMOVAL FROM THE PROGRAM.

WHAT DO YOU HOPE TO GAIN FROM WORKING WITH A STUDENT PERSONAL FITNESS TRAINER?

RANK ORDER THE FOLLOWING AREAS (ALL THAT APPLY) INDICATING WHICH YOU WOULD BE MOST INTERESTED IN WORKING ON WITH YOUR PERSONAL TRAINER. (1 = MOST IMPORTANT).

- | | |
|---------------------------------|---------------------------------------|
| ___ CARDIOVASCULAR MACHINES | ___ BACK CARE: STRENGTH & FLEXIBILITY |
| ___ RUNNING/WALKING PROGRAM | ___ ABDOMINAL STRENGTH |
| ___ CYBEX CIRCUIT EQUIPMENT | ___ WORKOUT PROGRAM FOR HOME |
| ___ FREE WEIGHTS (BEGINNER) | ___ WEIGHT MANAGEMENT |
| ___ FREE WEIGHTS (INTERMEDIATE) | ___ SPORT TRAINING: WHAT SPORT? _____ |
| ___ FLEXIBILITY | |

HOW WOULD YOU DESCRIBE YOUR EXERCISE HABITS (CIRCLE ONE)?

BEGINNER SEASONED, REGULAR ON AND OFF

WHAT IS YOUR CURRENT WORKOUT ROUTINE? (WHAT DO YOU DO, HOW OFTEN, HOW LONG, ETC.)

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DO YOU HAVE ANY PAST OR CURRENT HEALTH ISSUES THAT A TRAINER SHOULD KNOW ABOUT? (I.E., HEART DISEASE, DIABETES, JOINT INSTABILITY, BACK OR KNEE PAIN, PHYSICAL DISABILITY, PREGNANCY, RECENT SURGERIES, ETC.)

PLEASE PROVIDE DETAILS FOR ANY OF THE ABOVE OR FOR OTHERS NOT LISTED. IN ADDITION, PLEASE FILL OUT THE PARQ FORM PROVIDED AND FOLLOW THE INSTRUCTIONS – IF YOU ANSWER YES TO ONE OR MORE QUESTIONS, YOU MUST PROVIDE MEDICAL CLEARANCE FOR EXERCISE.

WHAT SPECIFIC QUESTIONS DO YOU HAVE ABOUT FITNESS IN GENERAL OR YOUR OWN FITNESS?

WHAT DAYS AND TIMES ARE YOU AVAILABLE? PLEASE RANK YOUR TOP FOUR TIMES FOR TRAINING. BE SPECIFIC. (EXAMPLE: M/W, 7 – 8 AM OR TU/FRI, 1 PM - VAGUE AND NON-SPECIFIC ANSWERS DECREASE YOUR CHANCES OF BEING PICKED UP BY THE STUDENT TRAINERS.)

TIME	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
6 AM					
7 AM					
8 AM					
9 AM					
10 AM					
11 AM					
12 PM					
1 PM					
2 PM					
3 PM					
4 PM					
5 PM					

APPLICATIONS WILL BE MATCHED TO TRAINERS BASED ON SCHEDULES AND AVAILABILITY. IF YOU HAVE QUESTIONS, PLEASE CONTACT THE DHFS WELLNESS PROGRAM AT DHFS.WELLNESS@GMAIL.COM.

Submit completed form to: Philemon Brown @ The Kinsolving Office,
Dawn Davis @ the Jester Office,
or email to dhfs.wellness@gmail.com

5-WEEK PERSONAL TRAINING PROGRAM

Meet regularly with a trainer, once per week, for 5 weeks (total of 5 sessions).

We'll work around **YOUR** schedule, from 6:00 am through 6:00 pm

Session I: 9/6-10/10

Session II: 10/17-11/23

Contact the Wellness Team at dhfs.wellness@gmail.com for an application form.

Space is limited. Participants must be able to commit to the 5-week program and attend 5 training sessions. Participants must use vacation or comp time to attend sessions during the workday.



**DHFS Wellness Program Personal Training
Participation Agreement Form**

Please read the following information that describes details of how the DHFS Personal Training Program “works.” If you agree and understand your commitment under each item, please initial in front of each number, to indicate that you are willing to abide by the program policies.

_____ 1. I understand that the student personal trainers are available to train once/week during the scheduled five-week session. Once I have scheduled an appointment I will only contact the trainer to reschedule in the event of a true emergency. Students are graded based on their number of training sessions, and I am committing to schedule and keep 5 appointments.

_____ 2. The information I have provided on the application form regarding schedule availability and health status is complete and accurate. I understand that trainers and clients are matched based on schedules, and that prior to participation I may be asked to provide a medical clearance form.

Employee Printed Name

Employee Signature

Date



Physical Activity Readiness Questionnaire (PAR-Q) and You

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:

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

**If
you
answered:**

YES to one or more questions

Talk to 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.

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.

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

Name _____

Signature _____

Signature of Parent _____

or Guardian (for participants under the age of majority)

Date _____

Witness _____

The University of Texas at Austin
Department of Kinesiology and Health Education
PARTICIPANT IN DHFS WELLNESS INITIATIVE
Associated with KIN 127, 227, 327, 627 Fieldwork classes
RELEASE AND INDEMNIFICATION AGREEMENT

(Please Print) Name

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I am the above named participant who is over eighteen years of age and am fully competent to sign this Agreement. In consideration of my participation in the Activity and use of the program's facilities and equipment, I hereby accept all risk to my health and of my injury that may result from my injury or death from such participation. I hereby release the above named institution, its governing board, officers, employees, and representatives from any liability to me, my personal representatives, estate, heirs, next of kin, and assigns for any and all claims and causes of action for loss of or damage to my property and for all illness or injury to my person, including my death, that may result from or occur during my participation in the Activity, whether caused by my negligence of the institution, its governing board, officers, employees, or representatives, or otherwise. I further agree to indemnify and hold harmless the Institution and its governing board, officers, employees, and representatives from liability for the injury or death of any person(s) and damage to property that may result from my negligent or intentional act or omission while participating in the described activity.

I have carefully read this agreement and understand it may be a release of all claims and causes of action for my injury or death or damage to my property that occurs while participating in the described activity and it obligates me to indemnify the partners named for any liability for injury or death of any person and damage to property that may be caused by my negligent or intentional act of omission. This agreement will be in effect starting on this date and through any subsequent semesters that I participate in the DHFS Wellness Initiative.

Signature: _____ Date: _____

PERTINENT MEDICAL INFORMATION:

Allergies. _____

Current Medication(s): _____

Other Medical Conditions Affecting full participation in physical activity; please also fill out attached ParQ)).
