



## PERSONAL TRAINING

### Welcome

Welcome and thank you for your interest in personal training at Auburn University. You have taken the first step towards better overall health! We thank you for allowing our Campus Recreation Personal Training team to be your guide. Our staff is dedicated to helping you reach your goals by promoting healthy, lifelong fitness behaviors! Before you can get started with your new personal trainer, please read this packet in its entirety and fill out all applicable forms. These forms are an important means for us to help you reach your goals safely and effectively. Congratulations on taking the next step to achieving a healthier you!

### Program policies & procedures

**Payment policy:** Campus Recreation charges a fee for services rendered by personal trainers. All services can be purchased anytime throughout the year at the campus recreation main office located on the 3<sup>rd</sup> floor in the Recreation and Wellness Center or via [Auburn University Online Payment Portal](#). Payment must be received before you will be scheduled for an assessment and/or session. Paying a personal trainer directly is strictly prohibited; all membership privileges will be terminated immediately.

**Expiration policy:** All personal training packages expire 120 days from the date of purchase. Personal training sessions are void after this time period. All personal training packages are non-refundable (see refund policy) and non-transferable.

**Refund policy:** Personal training packages are non-refundable except in cases of; termination of university employment; formal leave of absence and sabbaticals (documentation is required); changes in medical condition resulting in physical limitations (physician letter required).

**Late policy:** If you arrive more than 15 minutes late for the scheduled appointment, forfeiture of the session will result and the personal trainer has the right to leave the premises. All sessions are scheduled for 60 minutes and will end one hour from the scheduled start time.

**Cancellation policy:** If you must cancel or reschedule a training session, please notify your personal trainer by phone and/or email at least 24 hours in advance of the scheduled training session. Personal training sessions that are not rescheduled or canceled at least 24 hours in advance by the client will result in forfeiture of the session.

**Group Training Cancellation Policy:** If one client cancels within 24 hours of a scheduled group session or simply does not show, the session may continue with the remaining client(s). The session will still count toward the package balance for each of the clients.

**Registration policy:** The completed personal training registration packet (along with payment) must be received before you will be scheduled with a certified personal trainer. The completed registration packet can be returned either by email or at the campus recreation main office. Upon receipt of these materials, a member of our staff will contact you via email and/or phone within 72 hours to schedule your initial appointment.

**\*\*Please retain this page for your records\***

# AUBURN UNIVERSITY PERSONAL TRAINING REGISTRATION FORM

Name: \_\_\_\_\_

Date: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Auburn Affiliation:  STUDENT  FACULTY/STAFF  SPOUSE/PARTNER  RETIREE

Desired number of personal training sessions per week:  1  2  3  4  5

\*It is recommended that all participants work with their personal trainer at least 2-3 times per week.

Do you prefer a male or female trainer?  Male  Female  No Preference

Specific Trainer requested? \_\_\_\_\_

\*We will make every effort to accommodate requests, but they cannot be guaranteed. Assignments are based on client goals, fitness levels and schedules.

Please choose which days you are available to train: (Check all that apply)

Monday  Tuesday  Wednesday  Thursday  Friday  Saturday  Sunday

Please choose which blocks of time you are available to train: (Check all that apply)

6 a.m. - 9 a.m.  9am - 12 p.m.  12 p.m. - 4 p.m.  4 p.m. - 7 p.m.  7 p.m. - 10 p.m.

Select the package and number of sessions you would like to purchase:

One-On-One Personal Training  1  3  5  8  12  20  30

Buddy Personal Training (2 people)  3  5  10  20  30

Buddy Plus Personal Training (3 people)  3  5  10  20  30

Small Group Personal Training (4-6 People)  5  20  30

Training With (if purchasing Buddy, Buddy Plus or Small Group Training):

\_\_\_\_\_  
\*Please purchase Buddy or Buddy Plus packages once your group is set. We do not pair individuals for Buddy & Buddy Plus training, but will assist pairings for small group personal training\*

# Medical Health History Questionnaire

This form is not a substitute for a thorough physical examination, assessment, and/or diagnosis by your physician. It is designed to identify and understand potential issues that may arise due to an increase in physical activity. The Auburn University Lifetime Wellness & Fitness team strongly recommends that each client undergo a medical examination before beginning any exercise program. All information provided on this form is personal and confidential and will not be released to anyone except your referring physician without your written consent. The information you provide will enable us to better understand you and your health and fitness habits.

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Email Address: \_\_\_\_\_@auburn.edu Phone Number: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Auburn Affiliation:  Faculty/Staff  Student  Fr  So  Jr  Sr  Grad  Retiree  Spouse/Partner

Physicians Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Emergency contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

## I. Personal Fitness Goals & Exercise History

1. Please indicate your personal health and fitness goals: (check all that apply)

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Reduce Body Fat & Lose Weight                 | <input type="checkbox"/> Weight Gain                       | <input type="checkbox"/> Better Balance & Mobility      |
| <input type="checkbox"/> Increased Confidence & Energy                 | <input type="checkbox"/> Improve Stamina & Flexibility     | <input type="checkbox"/> Improve Nutrition              |
| <input type="checkbox"/> Build Lean Muscle Mass                        | <input type="checkbox"/> Muscular Strength                 | <input type="checkbox"/> Improve Cardiovascular Fitness |
| <input type="checkbox"/> General Health & Fitness                      | <input type="checkbox"/> Reduce Blood Pressure/Cholesterol | <input type="checkbox"/> Reshape Body                   |
| <input type="checkbox"/> Enhance Work, recreation & Sports Performance | Other: <input type="checkbox"/> _____                      |   |

Please tell us more about your specific short and long term goals for exercise, health, and fitness:

## 2. Exercise history

Yes No

Do you currently exercise? If yes, how many times per week? \_\_\_\_\_

If no, have you exercised in the past?

Have you ever worked with a fitness professional before?

If you currently exercise, what exercise activities does your workout program include?

## II. Signs and symptoms

3. Have you ever experienced any of the following: (check all that apply)

- |  |  |
|--|--|
| <input type="checkbox"/> Pain, discomfort, tightness or numbness in the chest, neck, jaw or arms | <input type="checkbox"/> Dizziness or Fainting     |
| <input type="checkbox"/> Shortness of breath at rest or with mild exertion                       | <input type="checkbox"/> Ankle Swelling            |
| <input type="checkbox"/> Difficult, labored or painful breathing during the day or night         | <input type="checkbox"/> Rapid pulse or heart rate |
| <input type="checkbox"/> Unusual shortness of breath or fatigue with usual activities            | <input type="checkbox"/> Claudication (Cramping)   |
| <input type="checkbox"/> Heart murmur and/or palpitations  | <input type="checkbox"/> Back Pain                 |
| <input type="checkbox"/> Severe headaches  | <input type="checkbox"/> Orthopedic problems       |

If you checked any of the above conditions, you must explain below:

## III. Medical diagnoses

4. Have you ever been diagnosed with, or suffered from: (check all that apply)

- |   |  |
|---|--|
| <input type="checkbox"/> Heart attack/heart disease | <input type="checkbox"/> Other Cardiac Surgery |
| <input type="checkbox"/> Coronary bypass            | <input type="checkbox"/> Pacemaker             |
| <input type="checkbox"/> Stroke                     | <input type="checkbox"/> Embolism              |
| <input type="checkbox"/> Aneurysm                   | <input type="checkbox"/> Angina Pectoris       |
| <input type="checkbox"/> Angioplasty                | <input type="checkbox"/> Phlebitis             |

If you checked any of the above conditions, you must have **medical clearance** prior to exercising. Please give details:

5. Have you ever been diagnosed with, or do you have any of the following: (check all that apply)

- |  |  |
|--|--|
| <input type="checkbox"/> Chronic bronchitis  | <input type="checkbox"/> Peripheral vascular disease   |
| <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Osteoporosis                  |
| <input type="checkbox"/> Osteopenia          | <input type="checkbox"/> Emphysema                     |
| <input type="checkbox"/> Asthma              | <input type="checkbox"/> Hypertension (>140/90 mmhg)   |
| <input type="checkbox"/> Thyroid problems    | <input type="checkbox"/> High cholesterol (>200 mg/dl) |
| <input type="checkbox"/> Emotional disorders | <input type="checkbox"/> Eating disorders              |
| <input type="checkbox"/> Cancer              | <input type="checkbox"/> Swelling of joints            |

If you checked any of the above conditions, please explain below:

#### IV. Major risk factors

- | 6. Please answer all of the following questions:  | Yes                      | No                       | Unsure                   |
|---|--------------------------|--------------------------|--------------------------|
| Are you a male over the age of 45 or<br>Female over the age of 55 who has had a hysterectomy or is postmenopausal?  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Has your father or brother experienced a heart attack before age of 55?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Has your mother or sister experience a heart attack before age of 65?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have impaired fasting glucose (diabetes)?<br>If yes, do you take insulin? What year was the diagnosis? _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have high cholesterol (>200ml/dl)?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Has your doctor ever told you that you might have high blood pressure?  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you currently smoke or have you smoked in the past 6 months?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have a sedentary lifestyle?  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

If you are a man over the age of 45 or a woman over the age of 55 or if you answered "yes" to two (2) or more of the above major risk factors, it is recommended that you receive a **physician's clearance** before beginning your exercise program.

#### V. General

- | 7. Please tell us more about you:                    | Yes                      | No                       |
|--|--------------------------|--------------------------|
| Are you currently pregnant?                          | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you currently on a special diet?                 | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you had a recent surgery in the past 12 months? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have seasonal allergies and/or hay fever?     | <input type="checkbox"/> | <input type="checkbox"/> |

ergogenic aids, diet supplements, vitamins, minerals, etc.

8. Please list any medications you are currently taking including but not limited to prescriptions, allergy medications,

Do you have allergies to any foods or medications?

Medication (supplement): \_\_\_\_\_ Reason: \_\_\_\_\_ Dosage: \_\_\_\_\_

Medication (supplement): \_\_\_\_\_ Reason: \_\_\_\_\_ Dosage: \_\_\_\_\_

Medication (supplement): \_\_\_\_\_ Reason: \_\_\_\_\_ Dosage: \_\_\_\_\_

Medication (supplement): \_\_\_\_\_ Reason: \_\_\_\_\_ Dosage: \_\_\_\_\_

I understand this medical health history questionnaire has been provided for the purpose of helping me better understand any potential risks associated with a workout program. I also understand I should share this information with my physician and seek his or her approval prior to beginning an exercise program. I understand the information I have provided will be maintained in my personal file for use in case of a medical emergency. My signature signifies that all of the above is true, to the best of my knowledge. Any information left unanswered was done so intentionally. If any of the above information changes, i agree to submit these changes in writing to the coordinator, personal training to update my personal training file.

Participant signature: \_\_\_\_\_ Date: \_\_\_\_\_

Fitness staff signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Staff Use Only**

Classification:  Low Risk  Moderate Risk  High Risk

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

# 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	
<input type="checkbox"/>	<input type="checkbox"/>	1. <b>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?</b>
<input type="checkbox"/>	<input type="checkbox"/>	2. <b>Do you feel pain in your chest when you do physical activity?</b>
<input type="checkbox"/>	<input type="checkbox"/>	3. <b>In the past month, have you had chest pain when you were not doing physical activity?</b>
<input type="checkbox"/>	<input type="checkbox"/>	4. <b>Do you lose your balance because of dizziness or do you ever lose consciousness?</b>
<input type="checkbox"/>	<input type="checkbox"/>	5. <b>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?</b>
<input type="checkbox"/>	<input type="checkbox"/>	6. <b>Is your doctor currently prescribing drugs (for example, water pills) for your blood pressure or heart condition?</b>
<input type="checkbox"/>	<input type="checkbox"/>	7. <b>Do you know of <u>any other reason</u> why you should not do physical activity?</b>

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 \_\_\_\_\_

SIGNATURE OF PARENT \_\_\_\_\_  
or GUARDIAN (for participants under the age of majority)

DATE \_\_\_\_\_

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.**



# Informed consent for participation

## 1) Objective of the Fitness Assessment

In order to permit the Lifetime Wellness & Fitness staff of the Auburn University Campus Recreation Department to design an exercise program appropriate for my current level of fitness, I hereby consent, voluntarily, to a fitness assessment. I understand that the tests that will be administered to me are for the purpose of determining my physical fitness status, and may include the measurement of my body composition, cardiorespiratory endurance, muscular endurance, muscular strength, flexibility, and static and dynamic posture. We now have the MicroFit HealthWizard Suite! MicroFit is the latest technology in fitness and wellness assessment software. This comprehensive program can identify our clients' health risks, assess fitness status, identify appropriate health improvement programs and track all outcomes. With all fitness assessments, clients will receive a print out to keep as a record.

## 2) Explanation of the Assessment

### Body Composition Assessment

Based on your specific goals, you may perform one or more of the following tests to determine your body composition. One method involves the use of Bioelectrical Impedance Analysis to determine your percentage of body fat. Skinfolds may also be taken to determine your percentage of body fat based on a 7-site test. Circumference measurements will also be used for some participants. These measurements are used to determine the girth of body segments.

### Cardiorespiratory Endurance Assessment

You will perform a sub-maximal treadmill test on a motorized treadmill. The exercise intensity will begin at a low level and will be advanced in stages depending on your fitness level. We may stop the test at any time because of signs of fatigue or when you have reached 85% of your predicted maximum heart rate. It is important that you realize that you may stop when you wish because of feelings of fatigue or any other discomfort.

### Muscular Strength and Endurance Assessment

Based on your specific goals, you may perform one or more of the following tests to determine your muscular strength and/or endurance. There are three tests that assess muscular endurance which include the push-up, sit-up and curl-up tests. The push-up and sit-up tests are maximum repetition assessments based on a one-minute time limit. The curl-up test is a 20 repetitions per minute test based on a metronome cadence. The right and left hand grip strength test will be used to measure muscular strength. The vertical jump test will be used to assess lower body muscular strength and power.

### Flexibility Assessment

You will perform a sit and reach test to assess the flexibility of your hamstring and lower back muscles.

### Static and Postural Assessments

As part of the assessment you will perform two tests to assess your static and dynamic posture. Static posture will be assessed through the use of a plumb line and/or AlignaBOD. We will observe your body position from three views: anterior, lateral and posterior. For dynamic posture, you will perform a Functional Movement Screen that consists of seven movement patterns to determine muscle imbalances, asymmetries and compensations.



## **Nutrition Assessment**

You will submit a 3-day dietary recall for analysis. A Registered Dietician and dietetic interns will make recommendations.

## **Personal Training**

You will be participating in a moderate to vigorous exercise program designed to improve your flexibility, balance, muscular strength and endurance and aerobic endurance.

### **3) Description of Potential Risks and Discomforts**

There exists the possibility of certain changes occurring during the fitness assessment. They include abnormal blood pressure, fainting, irregular, fast or slow heart rhythm, and in rare instances, heart attack, stroke, or death. Depending upon your level of conditioning you can expect some post exercise muscle soreness. Every effort will be made to minimize these risks by evaluation of preliminary information relating to your health and fitness and by observations during the assessment. Emergency procedures and trained personnel are available to deal with unusual situations that may arise.

### **4) Responsibilities of the Participant**

Information that you possess about your health status or previous experiences of unusual feelings with physical effort may affect the safety and value of your fitness assessment. Your prompt reporting of feelings with effort during the assessment itself is also of great importance. You are responsible for fully disclosing such information when requested by the staff members performing the assessment.

### **5) Benefits to be Expected**

The results obtained from the fitness assessment may assist in evaluating the type of physical activity you might do with low risk. It will also provide baseline data with which to compare future assessment results to determine the effectiveness of your fitness program.

### **6) Inquiries**

Any questions about the procedures used in the exercise or nutrition programs are encouraged. If you have any concerns or questions, please ask us for further explanations.

I have read this form, and I understand the procedures that I will perform and the attendant risks and discomforts. Knowing these risks and discomforts, and having had an opportunity to ask questions that have been answered to my satisfaction, I consent to participate in this activity.

Participant signature

Date

\_\_\_\_\_

\_\_\_\_\_

Parent/guardian (if participant is under 19 years of age)

Date

\_\_\_\_\_

\_\_\_\_\_

Signature of witness (fitness staff)

\_\_\_\_\_

By signing below I verify that I have read and understand the PROGRAM POLICIES AND PROCEDURES form received with this Personal Training Registration Packet.

Signature

Date

# Release and waiver of liability and indemnity agreement

In consideration of being permitted to participate in a fitness assessment, fitness programs, and/or personal training sessions, which may consist of warm-up, flexibility activities, cardiorespiratory endurance activities, muscular strength and endurance activities, body composition assessments, nutrition assessment, nutrition analysis, and/or nutrition consultation provided by the lifetime wellness & fitness program at auburn university. I, \_\_\_\_\_, the undersigned:

- 1) Hereby releases, waives, discharges and covenants not to sue auburn university, its board of trustees, officers, employees, agents, promoters, other participants, operators, trainers, sponsors and advertisers involved in said fitness assessment, fitness program, and/or personal training sessions, all for the purposes herein referred to as "releasee", from all liability to the undersigned, his personal representatives, assigns, heirs and next of kin for any and all loss or damage, and any claim or demands therefor on account of injury to the person or property or resulting in death of the undersigned, whether caused by the negligence of the releasee or otherwise while the undersigned is participating in any or all of the aforementioned activities.
- 2) Hereby agrees to indemnify and save and hold harmless the releasee and each of them from any loss, liability, damage, or cost they may incur due to the presence of the undersigned in or upon any area or in any way participating in the aforementioned activities whether caused by the releasee or otherwise.
- 3) Hereby assumes full responsibility for and risk of bodily injury, death or property damage due to the negligence of releasee or otherwise while in or upon the facilities of auburn university and while participating in any aforementioned activity.
- 4) I understand that i must have individual health insurance equal to or greater than the insurance offered by the auburn university student government association, to participate in auburn university health/wellness/fitness programs.
- 5) I expressly acknowledge and agree that the activities could be dangerous and involve risk of serious injury and/or death. I further expressly agree that the foregoing release, waiver, and indemnity agreement is intended to be as broad and inclusive as is permitted by law of the province or state in which the event is conducted and that if any portion thereof is held invalid, it is agreed that the balance shall, notwithstanding, continue in full legal force and effect. The undersigned has read and voluntarily signs the release and waiver of liability and indemnity agreement, and further agrees that no oral representations, statement or inducement apart from the foregoing written agreement have been made. By signing this document, i hereby acknowledge that i am at least 19 years of age and have read the above carefully before signing, and agree with all of its provisions this

\_\_\_\_\_ Day of \_\_\_\_\_, 201\_\_\_\_\_.

Participant signature

Parent/Guardian (if participant is under 19 years of age)

\_\_\_\_\_

\_\_\_\_\_

Signature of witness (fitness staff)

\_\_\_\_\_

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Participant signature

Date

\_\_\_\_\_

\_\_\_\_\_

Parent/guardian (if participant is under 19 years of age)

Date

\_\_\_\_\_

\_\_\_\_\_

Signature of witness (fitness staff)

\_\_\_\_\_



Lifetime Wellness & Fitness:  
**Nutrition Assessment Information**

*Our Registered Dietitian, Jessica-Lauren Roberts, and our Nutrition Team will analyze your recall and translate it into helpful information to help you reach your health goals. Please answer these questions to the best of your ability and with as much detail as possible. Return this form to Student Activities Center Office Trailer on Biggio Drive during business hours Monday-Friday. Call 334-844-4716 for assistance.*

Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_

E-mail: \_\_\_\_\_

Gender: \_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Age: \_\_\_\_\_

**What is your current physical activity in type, duration and frequency?**

Example: Walking 3 x a week for 30 minutes

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What are your **personal goals** regarding **nutrition**, health, weight, and exercise? Are you aiming to maintain, gain, or lose weight? Are you trying to change your body composition? Build healthier habits, and if so, what kind? Please help us give you the best feedback by giving us the appropriate info:

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Are you interested in a **personal consultation with our dietitian** or a Nutrition Team member to go over your nutrition assessment and set goals for your health?

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Please Note: You should report your food and beverage intake for **two** weekdays and one weekend day for a total of **three** days with as much detail as possible. Please see the example page for help. The Nutrition Team will analyze your intake using our nutrition analysis software and create a packet for you; please be expecting an email in the next 2-3 weeks saying that your information is ready for pick-up from a Nutrition Team Member in the Nutrition Office located on the second floor of the Student Activities Center.

**For Campus Rec/Nutrition Team Staff Only: Date turned in:** \_\_\_\_\_

**Date analyzed:** \_\_\_\_\_ **Date counseled:** \_\_\_\_\_

# Daily Food Log

Date	Time	Food & Ingredients	Method of Preparation or Brand Name	Quantity	Activity While Eating
9/30	8:00 AM	Strawberry Cheesecake Yogurt	Dannon Light	1 cup	watching TV
		Cereal	Fiber One	1/2 cup	
		Orange Juice	Tropicana with Calcium added	8 oz.	
	10:30 AM	Skittles		a handful	sitting in class
	12:00 PM	Sandwich:			lunch with friends
		whole wheat bread	Roman Meal	2 slices	
		american cheese	Kraft	1 piece	
		lean ham	Healthy Choice	4 slices	
		mayo, mustard	Kraft	1 tsp each	
		lettuce		1 leaf	
		regular chips	Doritos	1 sm. Bag	
		soft drink	Dr. Pepper	12 oz.	
	3:00 PM	Peanut Butter Crackers	Lance	6 crackers	walking to class
	7:00 PM	Pizza w/special garlic sauce	Papa John's Meat Lovers	3 slices	watching TV
		water		20 oz.	
	9:00 PM	soft drink	Pepsi	12 oz.	studying
		Chocolate Chip Cookies	Reduced-Fat Chips Ahoy	3 cookies	
	11:00 PM	water		8 oz.	getting ready for bed

# Daily Food Log

Date	Time	Food & Ingredients	Method of Preparation or Brand Name	Quantity	Activity While Eating

Name: \_\_\_\_\_



# Daily Food Log

Date	Time	Food & Ingredients	Method of Preparation or Brand Name	Quantity	Activity While Eating

Name: \_\_\_\_\_

# Daily Food Log

Date	Time	Food & Ingredients	Method of Preparation or Brand Name	Quantity	Activity While Eating

Name: \_\_\_\_\_