Campus Rec UNCG

SPARTAN SMALL GROUP TRAINING INFORMATION

Client Name:_____

Select One: (Circle)

Training Session 1
6:30-7:30AM Court 3
Meets Monday and Wednesday

Training Session 2
5:30-6:30PM TRX Studio
Meets Monday and Wednesday

Payment:

Student	$150
SRC Member	$170

Referred By:

_____

please print first and last name

OFFICE USE ONLY

DATE PAID] _____ **CHECK PACKAGE:** ***(circle status)***

Campus Rec UNCG

Informed Consent for Participation in a Spartan Small Group Training

- I hereby consent to voluntarily engage in a plan of small group training activities that are recommended to me for improvement of my general health and well being. The levels of exercise I perform will be based upon my cardiorespiratory and muscular fitness. I understand that I may be required to undergo a fitness assessment to evaluate my present level of fitness, and/or obtain physician consent to exercise. I will be given exact instructions regarding the amount and kind of exercise I should perform. I agree to participate in accordance with the personal trainer's instruction. Trained, personal fitness trainers will provide leadership to direct my activities, monitor my performance, and evaluate my effort.
- If I am taking prescribed medications, I have already so informed the Assistant Director, Fitness, and will inform the Assistant Director, Fitness of any changes my doctor or I make with regard to the use of prescription drugs.
- I have been informed that during my participation in the small group training, I will voluntarily complete the physical activities unless symptoms such as fatigue, shortness of breath, chest discomfort, or similar occurrences appear. At any point, I understand that it is my complete right to decrease or stop exercise, and it is my obligation to inform the personal trainer of my symptoms.
- I understand that during the performance of my small group training program, physical touching and/or positioning of my body may be necessary to assess my muscular and bodily reactions to specific exercises, and to ensure that I am using proper technique and body alignment. I expressly consent to physical contact for these reasons.
- I understand and have been informed that there exists the possibility of adverse changes and/or risk of bodily injury occurring during exercise including, but not limited to: abnormal blood pressure, fainting, dizziness, disorders of heart rhythm; in rare instances heart attack, stroke, or death; and injuries to muscles, ligaments, tendons, and joints. I have been told every effort will be made to minimize these occurrences by proper staff assessments of my condition before each exercise session, supervision during exercise, and by my own careful control of exercise efforts. I fully understand and accept the risks associated with exercise, including the risk of bodily injury, heart attack, stroke, or even death, but knowing these risks, it is my desire to participate as herein indicated.
- I understand that this program may benefit my physical fitness or general health, and if I follow the programs' instructions, my exercise capacity and fitness level may improve after a period of 3 to 6 months. However, the program cannot guarantee any particular level of improvement. I recognize that involvement in the small group training sessions will allow me to learn proper ways to perform conditioning exercises, use fitness equipment, and regulate physical effort.
- I have been informed that the information obtained in this small group training program will be treated as privileged and confidential and will consequently not be released or revealed to any person without my express written consent except as required by law or the courts. I agree to the use of any information for the purpose of consultation with other health/fitness professionals, including my doctor. Any other information obtained will only be used by the program staff in the course of recommending exercise for me and evaluating my progress in the program.
- I have been given the opportunity to ask certain questions as to the procedures of this program. I understand that other risks may be associated with this small group training program. I agree to hold UNCG, its trustees, agents and employees harmless from any claims related to any injury or illness that may result from my participation.
- By signing below, I hereby irrevocably consent to the unrestricted use by The University of North Carolina at Greensboro or its advertisers, customers, agents, successors and assigns, of my name, portrait or picture for advertising purposes or purpose of trade. I voluntarily waive the right to inspect or approve such completed portraits, pictures or advertising matter used in connection therewith.
- The privacy and confidentiality of your personal and health information is of paramount importance to us. Two federal acts, the Health Information Portability and Accountability Act 1996 better known as HIPAA and the Family Education Rights and Privacy Act or FERPA are the primary legal means protecting your rights to the privacy and confidentiality of your medical and educational records. In order to protect the confidentiality of your healthcare information, the Department of Campus Recreation will release or disclose information only with your signed authorization or as required or allowed by law. I understand that this release my also constitute a waiver of my privacy rights under The Federal Educational Rights and Privacy Act.
- Training will begin on time. If you are late the trainer can prevent you from participating that day. There are no refunds or no transferable registrations.

_____	_____	_____
Participant (Please Print)	*Participant (Signature)*	*Date*
_____	_____	
Assistant Director	*Date*	

Spartan Small Group Training Agreement

Eligibility

- Clients must be currently enrolled students or faculty, staff, alumni, and/or domestic partner Student Recreation Center Members.
- Clients will be required to complete the proper documentation prior to participation within the Small group training.
- The Department of Campus Recreation reserves the right to deny services to participants who may not be able to exercise safely within the program parameters.
- If it is determined that the client has one or more risk factors, based on the criteria set forth by the American College of Sports Medicine, that could be a potential risk during exercise, he/she will be referred to the Exercise and Sport Science Department for an in depth fitness assessment for a nominal fee before receiving any small group training from the Department of Campus Recreation.

Conduct of Training Sessions

- All sessions will be conducted at The University of North Carolina Greensboro, Student Recreation Center.
- Training sessions will be a maximum of 60 minutes in length. Attendance will be taken at each session.
- Training packages are non refundable and non transferable.
- Cancellations must be made by a minimum of 24 hours prior to the start of the scheduled training session time. Calling the Student Recreation Center at 334-5924 between 8am and 6pm, Monday through Friday, or the SRC main desk at 334-4030 to make cancellations during the hours of operation. Every effort will be made to reschedule a training session according to the mutual availability of the client and trainer.
- Small group training sessions must be conducted as six/eight-to-one (one trainer, six/eight client). Depending on space.
- Small group training will be conducted by a current Department of Campus Recreation Personal Training staff member only. Other personal trainers are not allowed to conduct training services within the Department of Campus Recreation facilities or on its grounds.
- Client must wear proper attire (i.e. shorts, sweat pants, t-shirt, tennis shoes etc.) Absolutely no jeans, jean shorts, sandals, open toe shoes of any kind.
- The first session is a fitness assessment for all clients. This will provide “baseline information” which will assist the trainer in providing adequate, but not excessive amounts of exercise, in terms of frequency, intensity and duration quantities. For this session, clients must wear proper workout attire. Shorts must be worn for both females and males. Females are highly encouraged to wear a sports bra for this session.

Small Group Training Sessions

- All small group training fees must be paid at the 4th floor receptionist desk in the UNCG Student Recreation Center.
- Small group training packages may not be split in any way with other clients regardless of their relationship to you. In addition, they can not be split between sessions or carried over from one six week program to another.
- All small group training sessions start at the time printed on the website. If the client is late the trainer can deny the client the opportunity to participate in that days activity.
- Trainers may not accept any direct or additional payment for their service**.**

Refunds

- Small group training sessions are non-transferable and non-refundable. Medical conditions, which prohibit the safe conduct of training sessions, that cause a delay in purchased sessions beyond 90 days plus grace period (of the date of purchase), will be refunded if a physician’s note is provided.

I have read and understand the following agreement.

_____	_____	_____
Client Name (Please Print)	Date	Phone Number
_____	_____	
Client Signature	Date	

Campus Rec UNCG

Exercise-Readiness Screening Questionnaire

Please complete this form as accurately and thoroughly as possible. This information will be kept confidential by the fitness program employees. It will be used to ascertain whether it is prudent for you to obtain consent from your physician and/or whether a fitness assessment is indicated BEFORE beginning or increasing your exercise program. If you do not understand how to complete a specific question, please seek assistance.

Name_____
(Last) (First) (Middle Initial)

Date: _____ Email Address:_____

Address: _____

_____

Phone: (H)_____(W)_____ UNCG ID #: _____

Circle: Male Female Date of Birth_____ Age____

Circle one: Freshman Sophomore Junior Senior Grad

Faculty/Staff Alumni Spouse/Partner Non-member

Medical/Surgical History

- ❑ Do you have any personal history of heart disease (coronary or atherosclerotic disease)?
- ❑ Any personal history of diabetes or other metabolic disease (thyroid, renal, liver)?
- ❑ Any personal history of pulmonary disease, asthma, interstitial lung disease or cystic fibrosis?
- ❑ Have you experienced pain or discomfort in your chest apparently due to blood flow deficiency?
- ❑ Any unaccustomed shortness of breath (perhaps during light exercise)?
- ❑ Have you had any problems with dizziness or fainting?
- ❑ Do you have difficulty breathing while standing or sudden breathing problems at night?
- ❑ Have you experienced a rapid throbbing or fluttering of the heart?
- ❑ Have you experienced severe pain in leg muscles during walking?
- ❑ Do you suffer from ankle edema (swelling of the ankles)?
- ❑ Do you have a known heart murmur?
- ❑ Has your serum cholesterol been measured at greater than 200 mg/dl?
- ❑ Has your HDL (the "good" cholesterol) been measured at greater than 60 mg/dl?
- ❑ Have you had a high fasting blood glucose level on 2 or more occasions (>=110mg/dl)?
- ❑ Are you 20% or more overweight or have you been told your “BMI” was greater than 30?
- ❑ Have you been assessed as hypertensive on at least 2 occasions (systolic > 140 mmHg or diastolic > 90mmHg)?
- ❑ Do you have any family history of cardiac or pulmonary disease prior to age 55?
- ❑ Are you a cigarette smoker?
- ❑ Would you characterize your lifestyle as "sedentary"?

If you checked one of the previous boxes, please provide us with the following information:

Physician's Name/Clinic _____
Contact Number _____

❑ Has your doctor ever said that you have a heart condition AND that you should only do physical activity recommended by a doctor?

❑ Do you feel pain in your chest when you do physical activity?

❑ In the past month, have you had chest pain when you were not doing physical activity?

❑ Do you lose your balance because of dizziness or do you ever lose consciousness?

❑ Do you have a bone or joint problem that could be made worse by a change in your physical activity?

❑ Is your doctor currently prescribing drugs (for example, water pills) for your blood pressure or heart condition?

❑ Do you know of any other reason why you should not do physical activity?

Medical History - Detail

❑ Are you currently being treated for high blood pressure?

If you know your average blood pressure, please enter: _____/_____

Please check all conditions or diagnoses that apply:

❑ Abnormal EKG?
❑ Abnormal Chest X-Ray?
❑ Rheumatic Fever?
❑ Low Blood Pressure?
❑ Asthma?
❑ Bronchitis?
❑ Emphysema?
❑ Other Lung Problems?
❑ Limited Range of Motion?
❑ Arthritis?
❑ Bursitis?
❑ Swollen or Painful Joints?
❑ Foot Problems?
❑ Knee Problems?
❑ Back Problems?
❑ Shoulder Problems?
❑ Recently Broken Bones?
❑ Stroke?
❑ Epilepsy or Seizures?
❑ Chronic Headaches or Migraines?
❑ Persistent Fatigue?
❑ Stomach Problems?
❑ Hernia?
❑ Anemia?
❑ Are You Pregnant?

❑ Has a doctor imposed any activity restrictions? If so, please describe:

_____

_____

_____

Family History

Have your mother, father, or siblings suffered from (please select all that apply):

- ❑ Heart attack or surgery prior to age 55.
- ❑ Stroke prior to age 50.
- ❑ Congenital heart disease or left ventricular hypertrophy.
- ❑ Hypertension
- ❑ Leukemia or cancer prior to age 60.
- ❑ High Cholesterol
- ❑ Diabetes
- ❑ Obesity
- ❑ Asthma
- ❑ Osteoporosis

At present…

Please select any medications you are currently using:

❑ Diuretics	❑ Other Cardiovascular
❑ Beta Blockers	❑ NSAIDS/Anti-inflammatory (Motrin, Advil)
❑ Vasodilators	❑ Cholesterol
❑ Alpha Blockers	❑ Diabetes/Insulin
❑ Calcium Channel Blockers	❑ Other Drugs (record below).

Please list the specific medications/supplements that you currently take:

_____
_____
_____
_____

1) Do you experience sudden tingling, numbness, or loss of feeling in your arms, hands, legs, feet, or face?
   Yes No

2) Have you ever noticed your hands and feet feel cooler than the rest of your body?
   Yes No

3) Do you get pains and/or cramps in your legs?
   Yes No

4) When was the last time you had a physical examination? Date: _____

5) Please list your last three hospitalizations:

	1	2	3
Type of operation:	_____	_____	_____
Date:	_____	_____	_____

**Adapted from the American College of Sports Medicine's Health/Fitness Standards & Guidelines*

The University of North Carolina at Greensboro
Department of Campus Recreation
Lifestyle Evaluation

Name: _____ Date: _____

SECTION 1: SMOKING

❑ Are you a cigarette smoker? If so, how many per day? _____

❑ Previously a cigarette smoker? If so, when did you quit? _____

How many years have you smoked or did you smoke before quitting? _____

Do you or have you smoked (Circle one): N/A Cigarettes Cigars Pipe

SECTION 2: STRESS

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.

Is your occupation: Inactive (desk job) Light activity (house work, light carpentry) Heavy activity (heavy carpentry, lifting)

SECTION 3: ALCOHOL INTAKE

❑ Do you drink alcoholic beverages?

If yes, How many units of alcohol do you consume per week: _____

(see Alcohol Units Chart)

Alcohol Units Table

Type of Drink	Units
1/2 pint of beer	1
1 glass of wine	1
1 pub measure of spirits (Gin, Vodka etc.)	1
1 can of beer	1.5
1 bottle of strong lager	2.5
1 can of strong lager	4
1 bottle of wine	7
1 liter bottle of wine	10
1 bottle of fortified wine (port, sherry etc.)	14
1 bottle of spirits	30

SECTION 4: DIETARY HABITS

Please select all that apply.

❑ I seldom consume red or high-fat meats.
❑ I pursue a low-fat diet.
❑ My diet includes many high-fiber foods.
❑ I eat at least 5 servings of fruits/vegetables per day.
❑ I almost always eat a full, healthy breakfast.
❑ I rarely eat high-sugar or high-fat desserts.

Do you consider yourself: Overweight Underweight At the correct weight

What is your current height and weight? _____Lbs. _____In.

What is your ideal weight? _____Lbs.

Have you ever dieted? Y / N If yes, by which weight loss method? _____

Which do you eat regularly and at what time do you normally eat?

Breakfast _____ am/pm

Midmorning snack _____ am/pm

Lunch _____ am/pm

Mid-afternoon snack _____ am/pm

Dinner _____ am/pm

After-dinner snack _____ am/pm

How often do you eat out per week? _____

What is your average portion size? Small Moderate Large Extra Large

SECTION 5: ACTIVITY HABITS

How many times per week are you active enough to break a sweat?_____

When you exercise, on average, how long are you active?_____ minutes

On a scale from 1-10 (10 being the greatest), how intense is your typical activity?_____

How many years have you exercised? _____

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

Running/Jogging	_____	Weight Training	_____	Skiing/Boarding	_____
Walking	_____	Aerobic Classes	_____	Yoga/Martial Arts	_____
Stair Climbing	_____	Swimming	_____	Other	_____
Bicycle/Spinning	_____	Racquet Sports	_____		

Place a check next to your activity preferences or interests

- ❑ Aerobic classes
- ❑ Group Activities
- ❑ Outdoor Cycling
- ❑ Step Aerobics
- ❑ Walking
- ❑ Free Weights
- ❑ Martial Arts
- ❑ Running
- ❑ Swimming
- ❑ Golf
- ❑ Spinning
- ❑ Tennis
- ❑ Other

SECTION 6: EXERCISE BELIEFS

For each age range rate your exercise level. (1 low-5 very strenuous)

15-20_____ 21-30_____ 31-40_____ 41-50_____ 51+_____

Rate yourself on a scale of 1-5 (1 being lowest and 5 the highest)

1. Characterize your present cardiovascular capacity.	1	2	3	4	5
2. Characterize your present flexibility capacity.	1	2	3	4	5
3. Characterize your present muscular capacity.	1	2	3	4	5

How much time are you willing to devote to an exercise program?

_____minutes/day _____days/week

Do you start exercise programs but then find yourself unable to stick with them?

YES NO

Do you experience depression/anxiety/anger when prevented from exercising?

YES NO

Can exercise take precedence over other non-exercise activities such as your social life, family, relationships, school or work responsibilities?

YES NO

Department of Campus Recreation
Personal Training
Client Goal Inventory

Name_____ Date_____

In striving to achieve a higher state of wellness or fitness, a set of clearly articulated goals is essential. These goals will help to guide your lifestyle choices such as when and what eat, how often and how intensely to exercise, and how to overcome the challenges and barriers you will surely encounter.

Please indicate your personal health and fitness goals: (Check all that apply)

❑ Aerobic Fitness	❑ Feel Better	❑ Flexibility	❑ General Fitness
❑ Improve Diet	❑ Injury Rehab	❑ Look Better	❑ Lose Weight
❑ Lower Cholesterol	❑ Muscular Size	❑ Muscular Strength	❑ Reduce Back Pain
❑ Reduce Stress	❑ Sport Specific	❑ Stop Smoking	

Please tell us more about your exercise patterns and goals:

Exercise History:

Needs:

Wants:

Activity Preferences:

Barriers to Success:

Motivation Level:

Confidence Level:

Evidence of Success:

Please use the reverse side to record three concrete commitments that you are willing to make to your own health goals. For example you might commit "To arrive, ready for exercise, on Mondays, Wednesdays and Fridays by 6:30pm." These should be challenging but realistic and attainable commitments. When finished, please sign this form to signify your personal commitment.

Concrete Commitments to Reach YOUR Goals:

1. _____
2. _____
3. _____

Signed: _____ Witnessed: _____