University of South Dakota • Wellness Center

PERSONAL TRAINING CONTRACT

Today's Date: _____

Membership Status: ☐ Student ☐ Member ☐ Non-Member Gender: ☐ Female ☐ Male

Name: _____ Date of Birth: _____ Age: _____

Address: _____ City: _____ State: _____ Zip: _____

Email: _____ Home/Cell Phone: _____ Work Phone: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

☐ New Client ☐ Return Client - (Request) Name of Trainer: _____

Physical Activity Readiness Questionnaire:

☐ Yes ☐ No Has a doctor ever said that you have a heart condition and recommended only medically supervised activity?
☐ Yes ☐ No Do you have chest pain brought on by physical activity?
☐ Yes ☐ No Have you developed chest pain in the past month?
☐ Yes ☐ No Have you on one or more occasions lost consciousness or fallen over as a result of dizziness?
☐ Yes ☐ No Do you have a bone or joint problem that could be aggravated by the proposed physical activity?
☐ Yes ☐ No Has a doctor ever recommended medication for your blood pressure or a heart condition?
☐ Yes ☐ No Are you aware, through your own experience, or a doctor's advice, of any other physical reason that would prohibit you from exercising without medical supervision?

If you answered "yes" to any of these questions, call your personal physician or healthcare provider before increasing your physical activity level.

Wellness Center Polices:

- Program Designs require a membership to the USD Wellness Center.
- Session packages are available to students/members/non-members.
- The Wellness Center reserves the right to refuse service if deemed fit.
- Session payments are non-refundable. Sessions are 60 minutes in length starting at your scheduled time. If you are more than 15 minutes late, it will be considered a No Show and you will be charged. You must call your personal trainer with cancellation at least 12 hours in advance before the session in order to reschedule.
- Program Design is good for 30 days after the original date of purchase.
- One session is good for 30 days after the original date of purchase.
- Five session packages are good for 60 days after the original date of purchase.
- Ten session packages are good for 90 days after the original date of purchase.
- 30 session packages are good for 180 days after the original date of purchase.

I state that I have read this document, agree with its terms and am signing this contract voluntarily.

Signature: _____ **Date:** _____

FOR OFFICE USE ONLY

	5 session	**10 sessions**	**20 sessions**	**30 sessions**
Single	☐ $120 + Tax	☐ $205 + Tax	☐ $395 + Tax	☐ $550 + Tax
Group (2)	☐ $70 + Tax	☐ $115 + Tax	☐ $195 + Tax	☐ $280 + Tax
Group (3-4)	☐ $55 + Tax	☐ $90 + Tax	☐ $140 + Tax	☐ $190 + Tax

Total Due: $ _____

Date Paid: _____

Paid by: ☐ Cash ☐ Credit Card

Staff Initials: _____

☐ Body Composition–$6 ☐ Program Design - Six Week Program–$80

UNIVERSITY OF SOUTH DAKOTA

University of South Dakota

WELLNESS CENTER

RELEASE AND WAIVER OF LIABILITY, ASSUMPTION OF THE RISK AND INDEMNITY AGREEMENT AND CONSENT TO MEDICAL TREATMENT

I understand that the use of the Wellness Center has inherent dangers, and may cause serious injury, damage to me person and/or property, and/or possible death. I fully assume all of the risks associated with the use of the Wellness center, including, but not limited to: negligence in design, maintenance, supervision, instruction or warning; inadequate safety equipment; the negligence of other users of the facility; misuse of the facility or its equipment by myself or others; surface hazards (slips, trips, and falls); collision with fixed or moving objects; and known and unknown physical weaknesses, frailties, diseases, and/or conditions which may cause or contribute to injuries, damages to my person or property, and possible death.

Types of injuries associated with physical activity include, but are not limited to: sprains, strains, contusions, fractures, joint dislocations, concussions, other types of musculoskeletal injuries, heart attacks, strokes, other types of ailments, and in rare cases, death. Furthermore, certain factors may increase the risk of injury. These risk factors include any form of tobacco, alcohol, or drug lifestyle, along with having a family history of any cardiovascular disease. The USD Wellness Center strongly recommends that if any individual has more than one of these risk factors that they seek the advice of a physician before becoming a member and beginning an exercise program. The further reduce the risk of injury; all individuals should begin new exercise programs at low levels of intensity and gradually increase the demands of exercise.

I understand that certain factors may increase the risk of suffering some type of injury. I further understand that I should cease exercising and/or activity and contract my physician if I experience any problems before, during, or after exercise sessions, including, but not limited to: dizziness, fainting or feelings of fainting; impaired vision; pain in the chest, neck, jaw area, or in the arms; shortness of breath; swelling in any of the joints; or unusual fatigue.

By my signature below, on behalf of myself, my heirs, next of kin, successors in interest, assigns, personal representatives, and agents, I hereby:

1. Waive any and all claims or causes of action against and release from liability the State of South Dakota, its officers, employees, and agents for any liability for injury, property damage, property loss, property theft, or death due to my use of the USD Wellness Center's facilities, equipment, and services.
2. Agree to indemnify and hold harmless the State of South Dakota, its officers, employees, and agents for any claims, causes of action, or liability to any other person arising from my voluntary participation in the Wellness Center activities; and
3. Consent to receive any medical treatment deemed advisable during my participation in the activity listed above.

I HAVE READ THIS RELEASE AND WAIVER OF LIABILITY, ASSUMPTION OF THE RISK AND INDEMNITY AGREEMENT AND CONSENT TO MEDICAL TREATMENT, FULLY UNDERSTAND ITS TERMS, UNDERSTAND THAT I HAVE GIVEN UP SUBSTANTIAL RIGHTS BY SIGNING IT, AND HAVE SIGNED IT FREELY AND VOLUNTARILY WITHOUT ANY INDUCEMENT, ASSURANCE, OR GUARANTEE BEING MADE TO ME AND INTEND MY SIGNATURE TO BE A COMPLETE AND UNCONDITIONAL RELEASE OF ALL LIABILITY TO THE GREATEST EXTENT ALLOWED BY LAW.

Name: _____ (please print)

Signature: _____

Date: _____

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USD WELLNESS CENTER
414 E. Clark Street, Vermillion SD 57069
605-677-8803 | fitness@usd.edu

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PERSONAL TRAINING NEW CLIENT REGISTRATION FORM

Today's Date: _____

- I prefer to be contacted via ☐ Email ☐ Phone ☐ Other: _____
- Have you ever worked with a personal trainer in the past? ☐ Yes ☐ No
- When would you like to begin your person training program? _____
- Are you interested in a Pre-Post Fitness Assessment? ☐ Yes ☐ No ☐ Maybe, tell me more.
- What day/time do you prefer to schedule sessions with a personal trainer?

  Preferred day of the week: _____ Preferred time of day: _____

Physical Activity:

1. Height: _____ Weight: _____
2. How much would you like to change your current weight? (+) _____ lbs. (–) _____ lbs.
3. In the past year, how often have you engaged in physical activity?

   ☐ Regularly (3-4 times/week) ☐ Semi Regularly (1-2 times/week) ☐ Sporadic (1-2 times/month) ☐ None
4. How long have you been exercising regularly? _____
5. When you exercise, rate your perceived exertion: ☐ Light ☐ Fairly Light ☐ Somewhat Hard ☐ Hard
6. Rate yourself on a scale of 1 to 5

   (*1 indicates the lowest value and 5 the highest*)

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

7. Do you start exercise programs but then find yourself unable to stick with them? ☐ Yes ☐ No
8. What are your personal barriers for not exercising or sticking to a program? _____
9. What types of exercise interest you? (Please check the boxes that apply)

   ☐ Walking ☐ Jogging ☐ Yoga/Pilates ☐ Cycling ☐ Fitness Classes ☐ Strength Training

   ☐ Elliptical striding ☐ Recreational ☐ Stair climbing ☐ Swimming ☐ Other: _____
10. Please explain your current exercise regime or activities performed in the past: _____
11. How much time do you plan on spending on your workout program with a trainer? _____ Day(s)/Week
12. Rate your goals in undertaking exercise: (*use the following scale to rate each goal separately*)

    _____ Reduction in Body-fat percentage
    _____ Improve cardiovascular function
    _____ Reshape or tone my body
    _____ Improve performance for a specific sport
    _____ Improve moods/ability to cope with stress
    _____ Improve flexibility
    _____ Increase strength
    _____ Increase energy level
    _____ Feel better
    _____ Other: _____

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Dietary Patterns:

1. How many meals and/or snacks do you have per day? _____
2. What would you estimate your caloric intake to be per day? _____
3. Do you feel you eat healthy "most of the time"? _____
4. Do you add salt to foods during cooking and/or at the table? ☐ Yes ☐ No
5. Do you minimize your intake of sweets, especially candy and soft drinks, and avoid adding sugar to foods? ☐ Yes ☐ No
6. Is your diet well-balanced (including vegetables, fruits, breads, cereals, dairy products, and adequate sources of protein? ☐ Yes ☐ No

Stress/Social:

1. How do you deal with stress normally? _____
2. Do you make decisions with minimum stress and worry? ☐ Yes ☐ No
3. Do you hold in your angry feelings without expressing them? ☐ Yes ☐ No
4. Do you have one or more persons with whom you can discuss personal worries/concerns? ☐ Yes ☐ No
5. Do they make you feel respected and/or admired? ☐ Yes ☐ No
6. Are you satisfied with the support you provide to others? ☐ Yes ☐ No

Occupation/Leisure:

1. What is your present occupation? _____
2. Does your occupation require much activity (i.e., walking, getting up & down, carrying things?) _____
3. What are your usual leisure activities? _____

Expectations:

1. Why have you decided to begin or improve your exercise program? _____
2. Why have you decided to hire a personal trainer? (Please check the boxes that apply)

   ☐ Need motivation and accountability ☐ Improve physical fitness
   ☐ Weight loss ☐ Improve strength
   ☐ Boredom with current workout ☐ Want to learn more about fitness
   ☐ Other: _____

3. Specifically describe what you would like to accomplish through your fitness program during the next:
   - 1 month: _____
   - 4 months: _____
   - 1 year: _____
4. What are you looking forward to most about starting a personal training program?

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MEDIAL HISTORY

Please assess your health status with true statements.

Indicate whether you **CURRENTLY HAVE** or **PREVIOUSLY HAVE HAD** a significant problem with any of the symptoms or conditions listed below:

History:

YES	NO	DON'T KNOW		YES	NO	DON'T KNOW	
☐	☐	☐	Heart attack	☐	☐	☐	Diabetes
☐	☐	☐	Heart surgery	☐	☐	☐	Exercise-induced Asthma
☐	☐	☐	Heart failure	☐	☐	☐	Bone, joint, or muscular injury
☐	☐	☐	Heart transplantation	☐	☐	☐	Arthritis
☐	☐	☐	Heart valve disease	☐	☐	☐	Eating disorder
☐	☐	☐	Stroke	☐	☐	☐	Pregnant
☐	☐	☐	Cancer				

If you answered "yes", please include comments below.

Signs & Symptoms:

YES	NO	DON'T KNOW	
☐	☐	☐	Pain, discomfort, tightness in chest, neck, jaw or arms
☐	☐	☐	Chest pain with exertion
☐	☐	☐	Shortness of breath at rest or with mild exertion
☐	☐	☐	Fainting, dizziness, or blackouts
☐	☐	☐	Unusual shortness of breath or fatigue with usual activities

Major Risk Factors:

YES	NO	DON'T KNOW	
☐	☐	☐	Body Mass Index ≥30 or a waist girth >100 cm (39.3 in.)
☐	☐	☐	Father or brother experienced a heart attack before the age of 55?
☐	☐	☐	Mother or sister experienced a heart attack before the age of 65?
☐	☐	☐	Smoke, or have quit in last 6 months
☐	☐	☐	High blood pressure (>140/90 mmHg)
☐	☐	☐	High blood cholesterol (>200 mg/dl)

If you answered "yes" to any of the major risk factor questions, call your personal physician or healthcare provider before increasing your physical activity level.

Medications/Vitamins:

Please list current medications/vitamins/supplements including over-the-counter medications, prescriptions, etc.

Name	Dosage	Purpose	Duration

Please list any known allergies (environmental, medications, foot, etc)

Family Medical:

Please indicate if any family member has had any of the following:

Medical Condition	Relationship	Comments
Obesity		
Heart Attack		
Stroke		
Cardiovascular Disease		
High Blood Pressure		
High Cholesterol		
Diabetes		
Cancer		
Osteoporosis		
Other:		

Is there anything that you did not get a chance to share that you would like us to know?

Thank you for your purchase of a personal training package. We look forward to working with you!

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