

Dear **MEMBER**.

Welcome! On the behalf of Drexel University's Recreation Center, I commend you on taking the initiative to *LIVE IT. fit!* I also appreciate you choosing our team as your partner in paving the road to achieving your health and fitness goals. The team here at Drexel's Rec Center is steadfastly committed to helping you accomplish your health and fitness goals.

In order for our team to provide the service you deserve and to expedite the process of getting started, we kindly request that you read and review this packet in its entirety and complete any applicable forms. This packet contains the following:

- LIVE IT. fit Policies
- Personal Contact and Biographical Information
- Physical Activity Readiness Questionnaire (PAR-Q)
- Health Risk Stratification and Release
- Health History Questionnaire
- Informed Consent for Fitness Assessment
- Medical Clearance Form (if necessary)

Completing this necessary documentation ensures the achievement of your goals in the most effective, efficient, and safest possible manner. Please return your completed forms and payment to the Membership Services Desk located near the side entrance to the Recreation Center on Market Street. If you have any questions or comments please contact me at your earliest convenience.

Appreciatively,

Joseph Giandonato, MS, CSCS Coordinator of Fitness Programs (215) 571-3771 jag476@drexel.edu



LIVEITfit Policies

Expiration Policy:

• All personal training packages expire six months after purchase date. All Personal Training packages are non-refundable (see refund policy) and non-transferable.

Refund Policy:

- A completed Membership/Program Refund Request Form is required to process any refund requests. This form
 is available at the Member Services desk and must be given to Joe Giandonato, Coordinator of Fitness Programs,
 for review
- Personal training packages are non-refundable except in the cases of:
 - o Termination of University employment
 - o Formal leave of absence and sabbaticals (documentation required)
 - o Changes in medical condition resulting in physical limitations (physician letter required)
 - o Move equal or greater than 30-mile radius from Drexel University (proof of residency required)
 - o Transferring of schools outside of the city limits

Scheduling Policy:

- All appointments must be scheduled through the Member Services desk at least 24 hours in advance (unless trainer states otherwise)
- No appointments can be scheduled without an active Personal Training Package or payment for service (if applicable)

Payment Policy:

- Payment must be made upon scheduling an appointment (if applicable)
- Methods of payment include: cash, check or credit card. All checks must be made payable to Drexel University.
- Paying a personal trainer directly is PROHIBITED—if done all membership privileges to the Drexel Recreation Center will be terminated effective immediately.

Lateness Policy:

- Clients should arrive to their appointments ON TIME. Sessions that begin late will still end 30 or 60 minutes after the scheduled start time.
- Clients arriving 15 minutes or more late for a session will forfeit the entire session.
- Clients may be instructed by the trainer to arrive early or stay later to complete work on their own at the discretion. However, doing so is not required.

Fitness Assessment Policy:

- Clients are advised to abstain from exercise prior to the assessment and should avoid ingesting caffeinated beverages or alcohol.
- Clients are instructed to wear athletic attire for the session and are advised to bring completed paperwork with them

Cancellation Policy:

• If a client must cancel or reschedule a training session, they must notify the Member Services desk by calling 215-571-3834, or come in person, at least 24 hours in advance of the scheduled session. Clients will be charged a session (if applicable) for appointments canceled within fewer than 24 hours' notice.



New Client Information Survey

The information contained in this survey will remain strictly confidential and will not be shared without the express written consent of the participant.

CONTACT INFORMATION

Name:	Date:	
Address:	Apartment or Unit Number:	
City: State	e:Zip:	
Phone Number:	Alternate Phone Number:	
E-mail address:	Alternate E-mail Address:	
Preferred Method of Contact:	What time is best to reach you?	
What is your relationship to Drex	el? (please select)	
□ Student □ Staff □ Faculty □	□ Alumni □ Community Member □ Corporate Partner □ Guest	
Are you a new or returning perso	nal training client? □ New □ Returning	
If returning, how long ago did you	ı last work with one of our personal trainers?	
	AVAILABILITY	
Please select which days and time	es correlate best with your schedule.	
Sunday: □ 10 AM-12 PM □ 12-3 PM □ 3-6 PM		
Monday: □ 6-9 AM □ 9 AM-12 PM □ 12-3 PM □ 3-6 PM □ 6-9 PM		
Tuesday: □ 6-9 AM □ 9 AM-12 PM □ 12-3 PM □ 3-6 PM □ 6-9 PM		
Wednesday: □ 6-9 AM □ 9 AM -1	.2 PM □ 12-3 PM □ 3-6 PM □ 6-9 PM	
Thursday: □ 6-9 AM □ 9 AM-12 I	PM □ 12-3 PM □ 3-6 PM □ 6-9 PM	
Friday: □ 6-9 AM □ 9 AM-12 PM	□ 12-3 PM □ 3-6 PM □ 6-9 PM	
Saturday: □ 8 AM-11 AM □ 11-2	PM □ 2-5 PM	



EMERGENCY CONTACT INFORMATION

Name:			Date:	
Address:			Apartment or Unit Number:	
City:		State:	Zip:	
Phone Nu	ımber:		Alternate Phone Number:	
E-mail address:			Alternate E-mail Address:	
		PHYSICIA	AN CONTACT INFORMATION	
Physician	ı's Name:			
Address:				
City:		State:	Zip:	
Please 1	This series	of questions deter	rivity Readiness Questionnaire (PAR-Q) rmines your readiness to begin physical activity. arefully and provide honest answers, checking YES or NO.	
YES	NO			
			 Has your physician ever diagnosed you with a heart condition, requiring you to perform 	
			physical activity as directed by a physician? 2. Do you experience chest pain when	
			performing physical activity? 3. In the past month, have you experienced chest	
			pain while not doing physical activity? 4. Do you lose your balance due to dizziness or	
			do you ever lose consciousness? 5. Do you have a bone or joint problem that	
			could be exacerbated by a change in your physical activity? 6. Is your physician prescribing medication for blood pressure or a heart condition?	
			7. Do you know of any other medical reason why you should not engage in physical activity?	



REQUIRED: HEALTH RISK STRATIFICATION

This series of questions analyzes risk factors for Coronary Heart Disease.

Please read and review the questions carefully and provide honest answers, checking YES or NO.

YES			
	1. You ar	re a man aged 45 or older.	
	□ 2. You ar	re a woman aged 55 or older. se tobacco or quit using tobacco within	
	□ 4. Your b	ious (6) months. blood pressure is greater than 140/90	
	mmol/L)	otal cholesterol exceeds 200 mg/dL (5.2), or low-density lipoprotein (LDL-C) 130 mg/dL (3.4-mmol/L).	
	□ 6. You ha □ 7. You ha who suff before the blood rel	ave prediabetes. ave an immediate male blood relative fered a heart attack or had heart surgery he age of 55 or an immediate female lative who suffered a heart attack or had regery before the age of 65.	
	currently moderat days per	re physically inactive (you do not y engage in at least 30 minutes of e intensity physical activity at least 3 week. Foody mass index (BMI) is greater than	
Please be advised if you've selected 'YES' to one or more risk factors listed above, you will require clearance from your physician before beginning a personalized fitness program.			
	VITAL		
1.	1. Height (in inches):		
2.	2. Weight (in pounds):		
3.	3. Gender:		
4.	4. Age: Please select from corresponding	age group below.	
	□18-25 □26-35 □36-45 □46-55 □5	6 – 65 □ 66 and older	



PHYSICAL ACTIVITY

7.	In the past year, how often have	you engaged i	n physical activit	y?	
	□ Frequently (5-6 times /we	eek)	□ Regularly (3	-4 times/wee	ek)
	□ Semi-regularly (1-2 times,	/week)	□ Sporadic (1-	2 times/mon	th)
	□ None				
8.	If you selected "None" in the prev partaking in an exercise program	-	, when was the la	ast time you	were actively
	□ one year to 18 months	□ 18 months	to three years	□ 3 – 5 yea	rs
	□ 5 -7 years	□ 8 – 10 yea	rs	□ 10 years	or more
9.	Please describe the nature of you group exercise classes, houseclear of each activity.				
10.	. What types of physical activity ha	ave you perfor	med in the past?	,	
11.	. What types of physical activity do	o you considei	enjoyable?		
12. Please list the types of physical activity that you don't like.					
13.	. Have you ever worked with a per	rsonal trainer?	'□ Yes □	No	
14.	Are you currently a member of a	gym or recrea	tional facility?	□ Yes	□ No
		LIFESTYL	Е		
15.	. Do you consume alcohol? Yes	s □ No			
16.	. If so, how much and how frequen	ntly?			



- 17. How many hours of sleep do you get per night?
- 18. How many times per week do you order or eat out?

MEDICAL HISTORY

Please indicate whether you currently suffer from or have suffered from a significant problem related to the conditions listed below by selecting the corresponding answer next to the number. Provide a description of each and its most recent occurrence, where applicable.

	Allergies
	Angina
	Anxiety
	Arthritis or Rheumatic condition
	Asthma
	Back Pain
	Bone, joint, or muscular pain (transient)
	Bronchitis
	Bursitis
	Cancer
	Change in appetite
	Chest pain with exertion
	Chronic fatigue
	Chronic bone, joint, or muscular pain
	Coronary Heart Disease (heart attack, bypass surgery, chest pain, heart murmur,
irregul	ar heart rhythm, et cetera)
	Depression
	Diabetes
	Dizziness
	Drug Allergies
	Eating Disorder
	Epilepsy
	Environmental Allergies
	Exercise Induced Bronchospasms
	Fainting
	Food Allergies
	Gastric Reflux or Heartburn
	Gastrointestinal Disorders
	Hearing Loss
	High Blood Cholesterol
	High Blood Pressure
	High Blood Triglycerides
	Hypoglycemia
	Incontinence
	Kidney Disorder
	Liver Disease



	Nausea Neck Pain
	Osteopenia
	Osteoporosis Persistent Headache
	Pregnancy or Recently Pregnant
	Recent Emergency Care
	Sleep Disorders (including Apnea, Insomnia, Narcolepsy, and Shift Work Disorder)
	Surgical Weight Reduction Procedure (gastric bypass, laparoscopic band, et cetera)
	Stroke
	Thyroid Condition
	Unexplained shortness of breath during physical exertion
	Unexplained weight loss or gain
	Urinary Tract Infection
	Vision Issues
	Vomiting Other conditions not listed (please specify):
19. I	s there any other medical condition not mentioned that may limit your physical activity?
	FAMILY MEDICAL HISTORY
significant	cate whether your family members currently suffer from or have suffered from a problem related to the conditions listed below by checking the corresponding number. vide a brief description.
	Cancer
	Diabetes
	High Blood Cholesterol
	High Blood Pressure
	High Blood Triglycerides Obesity
	Obesity Other conditions not listed (please specify):
	outer conditions not instea (piease speeny).
Comme	ents:



20. Other than your primary care doctor, have you seen any other physicians or ancillary healthcare providers in the past year? Briefly describe the condition and subsequent treatment plan.

MEDICATIONS

Please list current medications, including over-the counter medications and prescribed ones and the condition they are used to treat.

NUTRITION

21. Are you interested in a referral to nutrition counseling?22. Do you have any concerns with your eating habits? If yes, what are your concerns?23. Do you have any allergies or intolerances?24. Do you take any vitamin, nutritional or herbal supplements?

RESTRICTIONS

25. Are there any limitations not listed above that the Personal Training Staff should be made aware of?

EXPECTATIONS AND GOAL SETTING

- 26. Why have you decided to begin a program?
- 27. Are you looking to gain knowledge on exercise, injury prevention, and nutrition?
- 28. What are some of your expectations of the program?



Health History Questionnaire Acknowledgement

I understand the purpose of this Health History Questionnaire and I acknowledge that the staff of the Center will be relying on the accuracy and completeness of the information I have provided. I am aware that any strenuous physical activity involves risk, and I fully accept those risks. In consideration of the opportunity to participate in activities at the Center, I voluntarily remise, release and forever discharge Drexel University, its successors, assigns, trustees, officers, students, employees and agents from any and all personal injuries, damages, losses, claims, causes of action, or lawsuits of any kind whatsoever suffered by me as a result of my participation in any and all activities that I might undertake at the Center, including, without limitation, my fitness assessment.

By signing below, I am also consenting to first-aid, emergency medical care and, if necessary, admission to an accredited hospital or an emergency care center selected by staff at the Center or emergency response personnel if necessary for the provision of such care, for treatment of injuries that I may sustain while participating in activities at the Center. I understand and agree that I will be responsible for all expenses incurred in connection with any such first-aid, emergency medical care, including, without limitation, any and all expenses that may be associated with my transportation and admission to a hospital or emergency care center. I acknowledge and agree that my consent to medical care and my financial responsibility for such care is not conditioned on communication with the emergency contact identified above, or on confirmation of coverage of my medical insurance for such medical care.

I declare, to the best of my knowledge, that all my answers are true, correct, and complete.

By signing this Health History Questionnaire and Release, I hereby certify that I am 18 years of age

Witness Date:

Drexel University Recreation Center Staff Signature:



Informed Consent for Fitness Assessment

OBJECTIVE OF THE FITNESS ASSESSMENT

In order to permit the staff of the Drexel University Recreation Center 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 will include the measurement of my body composition, cardiovascular endurance, muscular endurance, muscular strength, and flexibility.

EXPLANATION OF FITNESS ASSESSMENT PROCEDURES

Body Composition: Body composition will be assessed by skin-fold calipers.

Standing and Seated Postural and Breathing Analysis: Photos will be taken of client while standing and seated to determine muscular imbalances and postural deficits.

Movement Assessment: Videos of client performing Functional Movement Screen will be recorded and analyzed by personal trainer to determine muscular imbalances in order to develop a personalized fitness program which will correct movement patterns, thus reducing injury. Cardiovascular Endurance: Cardiovascular endurance will be assessed via protocol(s) deemed appropriate by the personal trainer.

Muscular Strength and Endurance: Muscular strength and endurance will be determined through testing deemed appropriate by the personal trainer.

Flexibility: Flexibility will be assessed through testing deemed appropriate by the personal trainer.

BENEFITS TO BE EXPECTED

I understand the results of these tests will aid in determining my physical fitness status and will facilitate the design of an exercise prescription appropriate to my level of fitness.

I have read the forgoing information and I understand it. Questions concerning the fitness assessment procedures have been answered to my satisfaction. I also understand that I am free to deny answering any questions during the assessment, and that I may discontinue my participation in the assessment at any time. I understand that the information derived from my fitness assessment will be confidential and will not be disclosed to anyone other than my physician or others who are involved in my care or exercise prescription, without my permission.

I understand that there exists the possibility that certain abnormal changes may occur during the testing. These changes could include abnormal heart beats, abnormal blood pressure response, various muscle and joint strains or injuries, and in rare instances, heart attack or even death. Professional care throughout the entire testing process should provide appropriate precaution against such problems.

Signature:	Date:	
Drexel University Recreation Center Staff Signature:		
Witness	Date:	



Medical Clearance Form

Dear	
trainer at Drexel University's new client information surve	, would like to begin working with a personal s Campus Recreation Center. After reviewing their responses to our ey, we would appreciate your medical opinion and recommendations regular exercise. Please provide the following information and remit evenience to:
Joseph Giandonato, MS, CSCS Coordinator of Fitness Progr (215) 571-3771 (phone) (215) 895-2037 (fax) jag476@drexel.edu	
	de your patient a copy of this form to bring in to Membership Services y Campus Recreation Center.
	ncerns or conditions our staff should be made aware of prior to your itness program with a personal trainer?
	□ Yes □ No
If yes, please specify:	
2. If this individual has	completed a graded exercise test, please provide the following:
Date of test:	
A copy of the final exercise to	est report and interpretation:
Your specific recommendation	ons for exercise training, including HR limits during exercise:

3. Please provide the following information so that we may contact you if we have any further questions:



	I AGREE to the participation of my patient in a fitness program with a Drexel University Department of Recreation personal trainer.
	I DO NOT AGREE that this individual is a candidate for exercise at Drexel University's
	Recreation Center under the direction of a
	Department of Recreation personal trainer.
Physician's Signature:	Date:
Physician's Name:	
Address:	
Thank you for your consideration.	

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