ODU Recreation and Wellness
P.O.W.E.R.
Health History Form

Physician's Name: _____

Physician's Phone: _____

Person to contact in case of emergency:

Name: _____ Phone: ( )_____

When was your last physical examination? _____

Do you have any allergies? _____Yes _____No

If yes, please list: _____

Have you been hospitalized? If so:

1. Reason: _____ Date: _____
2. Reason: _____ Date: _____
3. Reason: _____ Date: _____

Are you taking any medications or drugs? If so, please list medication, dose and reason.

_____
_____
_____

Describe any physical activity you do somewhat regularly:

_____
_____
_____

Do you now, or have you experienced any of the following in the past:	YES	NO
1. History of heart problems, chest pains, or stroke?	_____	_____
2. Increased blood pressure?	_____	_____
3. Any chronic illness or infection?	_____	_____
4. Difficulty with physical exercise?	_____	_____
5. Advice from a physician not to exercise?	_____	_____
6. Recent surgery (last 12 months)?	_____	_____
7. Pregnancy (now or within last 3 months)?	_____	_____
8. History of breathing or lung problems?	_____	_____

	YES	NO
9. Muscle, joint, or back disorder, or any previous injury still affecting you?	_____	_____
10. Diabetes or thyroid condition?	_____	_____
11. Cigarette smoking habit?	_____	_____
12. Obesity (More than 20% over ideal body weight)?	_____	_____
13. Increased blood cholesterol?	_____	_____
14. History of heart problems in immediate family?	_____	_____
15. Hernia, or any condition that may be aggravated by lifting weights?	_____	_____
16. Has your weight fluctuated more than a few pounds?	_____	_____
17. Do you sometimes have trouble sleeping?	_____	_____
18. Have you suffered from migraine headaches?	_____	_____
19. Have you felt nervous or anxious for no apparent reason?	_____	_____
20. Have you experienced sudden tingling or numbness in your arms, legs, feet or your face?	_____	_____
21. Do you experience pain or cramping in your legs?	_____	_____

Please explain any YES answers:

_____
_____
_____

Please circle any conditions or diagnosis that applies to you:

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

Has your physician imposed activity restrictions? If yes, please describe:

_____
_____
_____

Family History

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

ODU Recreation and Wellness P.O.W.E.R. Training Informed Consent

I hereby consent to voluntarily engage in the personal training activities that are recommended for improvement of my health. The levels of exercise I complete are based upon my fitness level as determined by the fitness assessment. I will be given information and instructions on the type and amount of exercise that I should perform. I agree to participate in accordance with my personal trainers' instruction. Certified trainers will provide instruction and leadership for your activities and monitor my performance and effort.

If I am taking any medications I have already informed both my trainer and the Assistant Director/Coordinator of Fitness and Wellness in my medical history form and will update them with any changes made in my medication schedule.

I will complete my activities unless I feel dizzy, short of breath, chest pain, or fatigue occurs. I will notify my trainer if any of the above are experienced. I understand that it is my right to stop the exercise at any time.

I understand that during my training sessions, physical touching and/or positioning of my body may be necessary to be sure the activity is being done correctly so it does not cause injury. I consent to physical contact for that reason.

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, dizziness, fainting; in rare circumstances heart attack or death; and injuries to joints, tendons, and muscles. Every effort will be made to make sure these types of injuries do not occur, through assessments before the exercise is begun and proper supervision while exercises are being completed. I fully understand and accept the risks associated with exercise.

I understand that completing this program may improve my physical fitness and general well-being. I understand that participating in this program will not guarantee improvement at any level. I understand that participation in this program will help me learn proper ways to complete exercises and proper use of equipment.

I have been informed that any information obtained in the personal training program will be treated as confidential and will not be released to any person without my written consent except as required by law.

I have been given the opportunity to ask questions as it pertains to this program. I understand the risks associated with exercise and I agree to Old Dominion University Recreation and Wellness, its trustees, agents and employees harmless from any claims related to injury or illness that may result from my participation in the personal training program.

Participant Name (Please Print): _____ Date: _____
Participant Signature: _____
Assistant Director/Coordinator of Fitness and Wellness: _____

ODU Recreation and Wellness
P.O.W.E.R. Agreement

Eligibility

Clients must be a currently enrolled student, faculty, or staff, or dependents or spouses of Old Dominion University.
Clients are required to have their doctor complete the POWER Medical Clearance form in addition to completing the packet themselves.
ODU Recreation and Wellness reserves the right to deny training services to participants.

Conduct of Training Sessions

All sessions will be conducted in a Recreation and Wellness Facility (UFC or SRC), which will be previously agreed upon by the trainer and the participant. Training sessions will be a maximum of 60 minutes in length. Each client will have a training record that contains the number of sessions purchased and the name of the trainer. After each session both the trainer and the client are required to sign and date the record.
The client must wear appropriate workout attire (shorts, t-shirts, sweatpants, tennis shoes, etc.)
No jeans, sandals, or open toe/heel shoes of any kind.
The fitness assessment will give the trainer a baseline of information, which will aid the trainer in developing a training program that meets the clines level of need and ability. Appropriate workout attire is needed for the fitness assessment as well.

1. CANCELLATIONS: Clients must cancel a session 24 hours in advance or you will forfeit a session. To cancel you may call the Student Recreation Center at 757-683-3384 between 6 a.m. and 9 p.m. Every effort will be made to reschedule an appropriately cancelled training session. Client/trainer contact information should be known by both parties. If you can't contact your trainer, then call the Coordinator of Fitness and Wellness at 757-683-4517.
2. NO SHOW: If the client fails to give a 24 hour notification of cancellation, then restitution would be forfeiting a session.
3. LATE SHOWS: A 10 minute rule will apply for scheduled appointments. If you don't show within 10 minutes past your scheduled appointment, the personal trainer will not be obligated to train you on that particular day. If the trainer decides to leave after the 10 minutes, you will forfeit a paid training session. If the trainer stays and you show up, they will only train you for the remainder of the scheduled training hour.
4. Clients will be provided 12 sessions with a P.O.W.E.R. Trainer and can complete no more than two sessions per week.
5. After completion of the 12 sessions, the P.O.W.E.R. trainer will either request 12 more sessions to be completed by the client or release them from the program. When the client is released from the program, they may choose to continue with personal training or other Recreation and Wellness programs that might meet their needs.
6. If a third package of 12 sessions is recommended by the P.O.W.E.R. trainer, a physician's clearance form and recommendation for continuation of the program will be needed.

I have read, understand, and will abide by the above agreement.

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

Witness (Trainer) Signature: _____ Date: _____