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

- Weight loss
- Overall Fitness
- Reduce Stress
- Muscular Strength
- Improve Diet
- Stop smoking
- Lower Cholesterol
- Look Better
- Aerobic Fitness
- Sports Training
- Feel better
- Flexibility
- Muscular Size
- Reduce Pain
- Injury Rehab

What interests you about P.O.W.E.R.?

____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________

Training Expectations and Special Considerations (i.e. are you looking for a trainer long or short term, do you have any medical or other conditions your trainer should know about, etc.)

____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________

Comments:
ODU Recreation and Wellness Personal 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 Coordinator for 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: _________________________________________
Coordinator for 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 client’s 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 for 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.
• 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.

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

___________________________       _______________________________        __________________
Client Name (Please Print)  Client Signature    Date

Witness (Trainer) Signature: ______________________________        Date: ________________