SHEPHERD UNIVERSITY

Wellness Center

Private Yoga Training Packet

Revised: 09/2017

Package and Price

Yoga Instructor Rates:

Private yoga instructors hold nationally recognized certifications and have completed over 200 hours of yoga instruction.

Package (Sold under Athletic Performance packages)

3 (60 min.) sessions- $120
6 (60 min.) sessions- $215
12 (60 min.) sessions- $385

All packages require the completion of the yoga training packet prior to any services being rendered. Each package begins with a complimentary assessment to review health history, set goals, and evaluate flexibility, balance, and strength while moving through a flow of different postures*. The yoga instructor will create a program based on the outcome of the assessment.

*Movements in the assessment flow include:

- Arms overhead, looking up
- Hold at waist and touch shins & toes
- High plank
- Down dog
- Warrior One looks like a lung with arms extended
- Repeat

Client Services Policies

- Sessions must be booked at least 48- hours in advance.
- All appointments will be booked by the client through the instructor, the registration desk in the Wellness Center, or through the Wellness Center online system.
- All packages must be purchased prior to the booking of the service and will expire one year from purchase.
- Please arrive ready as sessions will begin and end promptly at the designated time.
- In the event of facility closure for any reason, the makeup appointment will be rescheduled at the instructors and clients' earliest convenience.
- If a client cancels less than 24-hours in advance of a private yoga session, or does not show, they may be charged for that session.
- If a client cancels less than 24-hours in advance of a complementary assessment, or does not show, they may forfeit their assessment.
- All cancellations should be directed to the Wellness Center registration desk at 304-876-5300 as soon as possible. If outside of our business hours, please email Jim Sweeney at jsweeney@shepherd.edu.
- Clients must have all documentation provided by the registration desk, the instructor, or available on our website completed prior to engaging in any physical activity with an yoga instructor.
- Each package purchased includes a complementary assessment that will be scheduled at the beginning of your package. The complementary assessment cannot be used as a private yoga session.

SHEPHERD UNIVERSITY *Wellness Center*

General Information & AHA/ACSM Preparticipation Screening Questionnaire

Name: _____ **Date:** _____

Age: _____ **Birthday:** _____ **Email:** _____

Phone Numbers (please indicate preferred contact number or times to call):

Mobile: _____ **Home:** _____

Assess your health status by marking all true statements

Cardiovascular Risk Factors:

- ☐ *You are a man older than 45 years*
- ☐ *You are a woman older than 55 years, have had a hysterectomy, or are post-menopausal*
- ☐ *You smoke, or quit smoking within the previous 6 months*
- ☐ *Your blood pressure is > 140/90 mm Hg*
- ☐ *You do not know your blood pressure*
- ☐ *You take blood pressure medication*
- ☐ *Your blood cholesterol is > 200mg/dL*
- ☐ *You do not know your cholesterol level*
- ☐ *You have a close blood relative who had a heart attack or heart surgery before age 55 (father or brother) or age 65 (mother or sister)*
- ☐ *You are physically inactive (i.e., you get <30 minutes of physical activity on at least 3 days per week for at least 3 months)*
- ☐ *You are >20 lbs overweight*
- ☐ *None of the above*

Signature:_____

PAR-Q+

Physical Activity Readiness Questionnaire

General Health Questions

Participating in physical activity is very safe for most people. This questionnaire will tell you whether it is necessary for you to seek further advice from your doctor OR a qualified exercise professional before becoming more physically active.

	Yes	No
1. Has your doctor ever said that you have a heart condition ☐ **OR** high blood-pressure ☐ ?		☐
2. Do you feel pain in your chest while at rest, **OR** during your daily activities **OR** when you do physical activity?	☐	☐
3. Do you lose balance because of dizziness or have you lost consciousness in the last 12 months? Please answer NO if your dizziness was associated with over-breathing (i.e. during vigorous exercise).	☐	☐
4. Have you ever been diagnosed with another chronic medical condition (other than heart disease or high blood pressure) List: _____	☐	☐
5. Are you currently taking prescribed medications for a chronic medical condition? Please list: _____	☐	☐
6. Do you currently have (or have had within the past 12 months) a bone, joint, or soft tissue (muscle, ligament or tendon) problem that could be made worse by becoming more physically active? Please answer NO if you had a problem in the past but it does not limit your current ability to be physically active. Please list: _____ _____	☐	☐
7. Has your doctor ever said you should only do medically supervised physical activity?	☐	☐

If you answered NO to all the above questions please skip pages 4, 5, and 6, and sign PARTICIPANT DECLARATION (p.4). **You are cleared for physical activity:**

- Participate in a fitness assessment
- Start becoming more physically active with gradual build up in vigorous activity
- If you are new to exercise, over the age of 45 and/or not accustomed to regular vigorous to maximal effort activity you may consider consulting with a qualified exercise professional before engaging in high intensity exercise.

🚫 **If you answered YES** to one or more of the questions above, please complete pages complete .

If you are currently experiencing temporary illness, are pregnant or experiencing changes in your health please consult with an exercise professional to determine if a Physician Release is needed before becoming more physically active.

PAR-Q+

Physical Activity Readiness Questionnaire

	Yes	No
Do you have Arthritis, Osteoporosis or Back Problems?	↓	☐
Do you have difficulty controlling your condition with medications or other physicians prescribed therapies? (Answer NO if you are not currently taking medications or other treatments)	☐	☐
Do you have joint problems causing pain, a recent fracture or fracture caused by osteoporosis or cancer, displaced vertebra (e.g. spondylolisthesis) and/or spondylolysis/pars defect (a crack in the bony ring on the back of the spinal column)?	☐	☐
Have you had steroid injections or taken steroid tablets regularly fir more than 3 months?	☐	☐
Do you currently have Cancer of any kind?	↓	☐
Does your cancer diagnosis include any of the following types: lung/bronchogenic, multiple myeloma (cancer of plasma cells), head, and/or neck?	☐	☐
Are you currently receiving cancer therapy (such as chemotherapy or radiotherapy)?	☐	☐
Do you have a Heart or Cardiovascular Condition? *This includes Coronary Artery Disease, Heart Failure, Diagnosed Abnormality of Heart Rhythm*	↓	☐
Do you have difficulty controlling your condition with medications or other physicians prescribed therapies? (Answer NO if you are not currently taking medications or other treatments)	☐	☐
Do you have an irregular hearts beat that requires medical management? (e.g., atrial fibrillation, premature ventricular contraction)	☐	☐
Do you have chronic heart failure?	☐	☐
Do you have High Blood Pressure?	↓	☐
Do you have difficulty controlling your condition with medications or other physicians prescribed therapies? (Answer NO if you are not currently taking medications or other treatments)	☐	☐
Do you have a resting blood pressure equal to or greater than 140/90 mmHg with or without medication? (Answer YES if you do not know your resting blood pressure)	☐	☐

PAR-Q+

Physical Activity Readiness Questionnaire

	Yes	No
Do you have any Metabolic Conditions? *This includes Type 1 Diabetes, Type 2 Diabetes, Pre-Diabetes?*	↓	☐
Do you often have difficulty controlling your blood sugar levels with foods, medications, or other physician prescribed therapies?	☐	☐
Do you often suffer from signs and symptoms of low blood sugar (hypoglycemia) following exercise and/or during activities of daily living? Signs of hypoglycemia may include shakiness, nervousness, unusual irritability, abnormal sweating, dizziness or lights headedness, mental confusion, difficulty speaking, weakness, or sleepiness.	☐	☐
Do you have any signs or symptoms of diabetes complications such as heart or vascular disease and/ or complications affecting your eyes, kidneys, OR the sensation in your toes and feet?	☐	☐
Do you have other metabolic conditions (such as current pregnancys related diabetes, chronic kidney disease, or liver problems)?	☐	☐
Are you planning to engage in what for you is unusually high (or vigorous) intensity exercise in the near future?	☐	☐
Do you have any Mental Health Problems or Learning Difficulties? ***This includes Alzheimer's, Dementia, Depression, Anxiety Disorder, Eating Disorder, Psychotic Disorder, Intellectual Disability, Down Syndrome?***	↓	☐
Do you have difficulty controlling your condition with medications or other physicians prescribed therapies? (Answer NO if you are not currently taking medications or other treatments)	☐	☐
Do you have Down Syndrome AND back problems affecting nerves or muscles?	☐	☐
Do you have a Respiratory Disease? ***This includes Chronic Obstructive Pulmonary Disease, Asthma, Pulmonary High Blood Pressure***	↓	☐
Do you have difficulty controlling your condition with medications or other physicians prescribed therapies? (Answer NO if you are not currently taking medications or other treatments)	☐	☐
Has your doctor ever said your blood oxygen level is low at rest or during exercise and/or that you require supplemental oxygen therapy?	☐	☐
If asthmatic, do you currently have symptoms of chest tightness, wheezing, labored breathing, consistent cough (more than 2 days/week), or have you used your rescue medication more than twice in the last week?	☐	☐
Has your doctor ever said you have high blood pressure in the blood vessels of your lungs?	☐	☐

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Physical Activity Readiness Questionnaire

	Yes	No
Do you have a Spinal Cord Injury? ***This includes Tetraplegia and Paraplegia***	↓	☐
Do you have difficulty controlling your condition with medications or other physicians prescribed therapies? (Answer NO if you are not currently taking medications or other treatments)	☐	☐
Do you commonly exhibit low resting blood pressure significant enough to cause dizziness, lights headedness, and/or fainting?	☐	☐
Has your physician indicated that you exhibit sudden bouts of high blood pressure (known as Autonomic Dysreflexia)?	☐	☐
Have you had a Stroke? ***This includes Transient Ischemic Attack (TIA) or Cerebrovascular Event***	↓	☐
Do you have difficulty controlling your condition with medications or other physicians prescribed therapies? (Answer NO if you are not currently taking medications or other treatments)	☐	☐
Do you have any impairment in walking or mobility?	☐	☐
Have you experienced a stroke or impairment in nerves or muscles in the past 6 months?	☐	☐
Do you have any other medical condition not listed above or do you have two or more medical conditions?	↓	☐
Have you experienced a blackout, fainted, or lost consciousness as a result of a head injury within the last 12 months OR have you had a diagnosed concussion within the last 12 months?	☐	☐
Do you have a medical condition that is not listed (such as epilepsy, neurological conditions, kidney problems)?	☐	☐
Do you currently live with two or more medical conditions?	☐	☐

PLEASE LIST YOUR MEDICAL CONDITION(S) AND ANY RELATED MEDICATIONS HERE:

Delay becoming more active if:

- You have a temporary illness such as a cold or fever; it is best to wait until you feel better.
- You are pregnant - talk to your health care practitioner, your physician, a qualified exercise professional before becoming more physically active.
- Your health changes - talk to your doctor or qualified exercise professional before continuing with any physical activity program.

PAR-Q+

Physical Activity Readiness Questionnaire

☑ **<u>If you answered NO</u> to all of the follow-up questions about your medical condition, you are ready to become more physically active:**

- It is advised that you consult a qualified exercise professional to help you develop a safe and effective physical activity plan to meet your health needs.
- You are encouraged to start slowly and build up gradually - 20 to 60 minutes of low to moderate intensity exercise, 3-5 days per week including aerobic and muscle strengthening exercises.
- As you progress, you should aim to accumulate 150 minutes or more of moderate intensity physical activity per week.
- If you are over the age of 45 years and NOT accustomed to regular vigorous to maximal effort exercise, consult a qualified exercise professional before engaging in this intensity of exercise.

Please sign the PARTICIPANT DECLARATION below

⊗ **<u>If you answered YES</u> to one or more of the follow-up questions about your medical condition:**

- You should seek further information before becoming more physically active or engaging in a fitness appraisal.
- Please have your physician complete the "PHYSICAL ACTIVITY READINESS PHYSICIAN REFERRAL FORM" on page 8. Physicians can email the completed form back to jsweeney@shepherd.edu.

The authors, the PAR-Q+ Collaboration, partner organizations, and their agents assume no liability for persons who undertake physical activity and/or make use of the PAR-Q+ or ePARmed-X+. If in doubt after completing the questionnaire, consult your doctor prior to physical activity.

PARTICIPATION DECLARATION

All persons who have completed the PAR-Q+ please read and sign the declaration below. If you are less than the legal age required for consent or require the assent of a care provider, your parent, guardian or care provider must also sign this form.

I, the undersigned, have read, understood to my full satisfaction and completed this questionnaire. I acknowledge that this physical activity clearance is valid for a maximum of 12 months from the date it is completed and becomes invalid if my condition changes. I also acknowledge that a Trustee (such as my employer, community/fitness center, health care provider, or other designate) may retain a copy of this form for their records. In these instances, the Trustee will be required to adhere to local, national, and international guidelines regarding the storage of personal health information ensuring that the Trustee maintains the privacy of the information and does not misuse or wrongfully disclose such information.

Name	*Date*
Signature	*Witness*
Signature of Parent/Guardian	

The PAR-Q+ was created using the evidence-based AGREE process (1) by the PAR-Q+ Collaboration chaired by Dr. Darren E. R. Warburton with Dr. Norman Gledhill, Dr. Veronica Jamnik, and Dr. Donald C. McKenzie (2). Production of this document has been made possible through financial contributions from the Public Health Agency of Canada and the BC Ministry of Health Services. The views expressed herein do not necessarily represent the views of the Public Health Agency of Canada or the BC Ministry of Health Services.

SHEPHERD UNIVERSITY Wellness Center

PHYSICAL ACTIVITY READINESS PHYSICIAN REFERRAL FORM

Based on the current review of the health status of _____(name)
I recommend the following course of action:

- ☐ The participant should avoid engaging in physical activity at this time.
- ☐ The participant should engage in only a medically supervised physical activity/exercise program involving the supervision of a qualified exercise professional (or other appropriately trained health care professional) and overseen by a physician.
- ☐ The participant is cleared for intensity and mode appropriate physical activity/exercise training under the supervision of a qualified exercise professional.
- ☐ The participant is cleared for intensity and mode appropriate physical activity/exercise training with limited supervision (i.e., unrestricted physical activity).

The following precautions should be taken when prescribing exercise for the aforementioned participant:

- With the avoidance of: _____
  _____
  _____
  _____

- With the inclusion of: _____
  _____
  _____
  _____

NAME OF PHYSICIAN: _____

ADDRESS: _____

TELEPHONE: _____

Date of Medical Clearance (mm/dd/yy): _____

Please email completed form to the Shepherd University Wellness Center: jnels01@shepherd.edu.

PHYSICIAN/CLINIC STAMP AND SIGNATURE

NOTE: This physical activity/exercise clearance is valid for a period of six months from the date it is completed and becomes invalid if the medical condition of the above named participant changes/worsens.

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SHEPHERD UNIVERSITY *Wellness Center*

EXERCISE HISTORY FORM

General Instructions: Please fill out this form as completely as possible. If you have any questions, ask your instructor for assistance.

1. Please rate your exercise level on a scale of 1 to 5 (5 indicating very strenuous) for each age range through your present age: 16-20 _____ 21-30 _____ 31-40 _____ 41+50 _____

2. Were you a high school and/or college athlete? _____ Yes _____ No

If yes, please specify _____

3. Do you have any negative feelings towards, or have you had any bad experiences with , physical activity programs? _____ Yes _____ No

If yes, please specify _____

4. **Do you have any negative feelings towards, or have you had any bad experiences with fitness testing and evaluation?** _____ Yes _____ No

Is yes, please specify _____

5. Rate yourself on a scale of 1 to 5 (1 indicating the lowest value, 5 the highest). Circle the number that best applies.

Characterize your present athletic ability.	1	2	3	4	5
When you exercise, how important is competition?	1	2	3	4	5
Characterize your present cardiovascular capacity.	1	2	3	4	5
Characterize your present muscular capacity.	1	2	3	4	5
Characterize your present flexibility capacity.	1	2	3	4	5

6. Are you currently involved in regular cardiovascular exercise? _____ **Yes** _____ **No**

If yes, specify the type of exercise(s) _____ ___ Minutes a Day, ___ Day a Week

Rate the perceived exertion of your cardiovascular program:

_____ Light _____ Fairy Light _____ Somewhat Hard _____ Hard

7. What are your fitness goals?

_____ Fat/Weight Loss
_____ Cardiovascular
_____ Flexibility
_____ Improve Disability
_____ Muscular Strength
_____ Tone/Firm Muscles
_____ Reshape Body
_____ Reduce Risk Factors
_____ Muscular Endurance
_____ Increase Muscle Mass
_____ Reduce Stress
_____ Sport Specific

STAFF USE ONLY (Write Type of Program Here)

SHEPHERD UNIVERSITY *Wellness Center*

CONSENT & RELEASE LIABILITY FORM

1. The exercise sessions you will become involved with will consist of progressive exercise levels that will be determined and regulated by your trainer. The exercise sessions may consist of aerobic and weight training as well as education and instruction. These exercises are designed to place gradually increasing stress on the body to improve its function, although no guarantee can be made. The trainer will provide spotting and cueing to ensure your safety and at anytime where it would require physical touch, he or she will ask for permission. You have the right to refuse and the exercise will be eliminated for safety reasons.

Initial _____

2. I am aware that all activities are offered as recreational or self directed in nature and I have the right and choice to stop activity at any time. I also assume full responsibility during and after my participation for any risk, discomfort or fatigue that I may experience. I understand that exercise and cardiovascular activity and the response of my body to such activity cannot be predicted. I acknowledge my responsibility and obligation to inform my trainer of any pain, discomfort, fatigue or any other symptoms that I may suffer. It is my choice to participate in the training program. I accept assumption of all the risk that may imply as my own.

Initial _____

3. The information made or gathered during the training sessions is treated as confidential.

Initial _____

4. I understand that I may ask questions or request further information about any of the activities, programs, or services offered by my Shepherd University Wellness Center trainer at any time. It is my choice to participate in the programs offered and may withdrawal from participation as I wish.

Initial _____

5. I understand that all personal training sessions must be paid for in advanced and that I must give 24-hours notice prior to canceling a session. I understand that without given 24-hour notice or not showing up may result in being charged for the scheduled session.

Initial _____

6. I understand that all sessions must be used within one (1) year of purchase date and are not transferable.

Initial _____

I have read and consent to the above information and wish to participate in an exercise program with personal trainer from the Shepherd University Wellness Center.

_____

Signature Date

_____

Trainer Date