SHEPHERD UNIVERSITY

Wellness Center

Private Yoga Training Packet

Revised 01/2022

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- $132
6 (60 min.) sessions- $236.50
12 (60 min.) sessions- $423.50

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 Josh Nelson at jnels01@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.

EXERCISE PREPARTICIPATION HEALTH-SCREENING QUESTIONNAIRE

Name: _____ Age: _____ Birthday: _____
Email: _____ Phone Number: _____

Assess your health needs by marking all *true* statements.

Step 1

SYMPTOMS

Do you experience:

- ☐ chest discomfort with exertion
- ☐ unreasonable breathlessness
- ☐ burning or cramping sensations in your lower legs when walking short distances
- ☐ dizziness, fainting, blackouts
- ☐ ankle swelling
- ☐ unpleasant awareness of a forceful, rapid, or irregular heart rate

If you **did** mark any of these statements under the symptoms, **STOP,** and seek medical clearance before engaging in or resuming exercise. You may need to use a facility with a **medically qualified staff**. Please complete the last page of this packet. If you **did not** mark any symptoms, continue to steps 2 and 3.

Step 2

CURRENT ACTIVITY

Have you performed planned, structured physical activity for at least 30 minutes at moderate intensity on at least 3 days per week for at least the past 3 months?

Yes ☐ No ☐

Continue to Step 3.

Step 3

MEDICAL CONDITIONS

Have you had or do you currently have:

- ☐ a heart attack
- ☐ heart surgery, cardiac catheterization, or coronary angioplasty
- ☐ pacemaker/implantable cardiac defibrillator/rhythm disturbance
- ☐ heart valve disease
- ☐ heart failure
- ☐ heart transplantation
- ☐ congenital heart disease
- ☐ diabetes
- ☐ renal disease

Evaluating Steps 2 and 3:

- If you **did not mark any of the statements in Step 3,** medical clearance is not necessary.
- If you marked Step 2 **"yes"** and **marked any of the statements in Step 3,** you may continue to exercise at light to moderate intensity without medical clearance. Medical clearance is recommended before engaging in vigorous exercise.
- If you marked Step 2 **"no"** and **marked any of the statements in Step 3,** medical clearance is recommended. You may need to use a facility with a **medically qualified staff.** Please complete the last page of this packet.

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

Please list any special considerations (i.e., medical condition, medications, injuries, pain with movement, limited range of motion):

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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

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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: mmorr01@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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