STONY BROOK FIT CLUB

Presented by: CAMPUS RECREATION

APPLICANT INFORMATION												
Name							SOLAR ID					
Local Address							Apartment/Box #					
City			State				ZIP					
Phone (ext)			E-mail Address									
☐ Male	☐ Female	Weight		Height			Date of Birth					
☐ First Year	☐ Sophomore		☐ Junior		☐ Senior		☐ Grad.		☐ Faculty/Staff			
Major/Department					Shirt Size		☐ S	☐ M	☐ L	☐ XL	☐ XXL	
How did you hear about us?	☐ Wellness Programs		☐ Email		☐ Online		☐ Facebook		☐ Other			

SB FIT CLUB! FALL 2010 AVAILABILITY

Please indicate your priorities by selecting/adding your TOP 3 time slots. Most desired=1, Least desired = 3. Based on your selected availability we will set up times for group workouts, workshops and more.

____ 9:00am-10:00am-**Mondays** _____ -**Mondays** ____ 8:30-10:00am-**Tuesdays**

____ 7:30-9:00pm-**Tuesdays** ____ 9:00-10:00am-**Wednesdays** ____ 1:00-2:00pm-**Wednesdays**

____ 8:30-9:30pm-**Wednesdays** ____ 9:00-10:30am-**Thursdays**

____ 9:00-11:30am-**Fridays** ____ 5:15-7:00pm-**Fridays**

AGREEMENT

☐ **I agree to pay the $50.00 (faculty & staff) or $30.00 (students) participation fee on or before 9/16/2011, if selected as a participant for SB FIT CLUB! I am aware that photos/video may be taken during the course of the program and The Department of Campus Recreation can use the media to its discretion.**

Signature		Date	

ESSAY (3 PARAGRAPH MIN.)

Please attach a response to the following questions: **Why do you want/Why should you be accepted to be a part of the Stony Brook FIT CLUB?** And **What prevents you from maintaining a healthy lifestyle?**

***** Completed applications are due to the SAC Wellness Office, room 225 no later than 5pm, February 8, 2012. Participants will be notified of acceptance into the program via e-mail February 10, 2012. Participants may be asked to obtain physician's consent prior to participation in this program. *****

Liability/Informed Consent

Please read the following Liability/Informed Consent Form. If you wish to proceed with your fitness assessment, personal training or exercise program please sign where indicated.

A fitness assessment may include the following: a cardio respiratory endurance test, muscular strength and endurance test, flexibility test, and body composition assessment. The purpose is to evaluate your current fitness level and help measure your ability to perform physical work. We recommend that you consult with your physician before participating in these exercises.

With this assessment, we hope to determine what can be done to improve your physical condition. Although complications have been few during exercise testing, risks do exist. If a person exercising is not tolerating the experience well, it usually becomes apparent and the exercise will be stopped. You are urged to report any unusual symptoms during the fitness assessment, and may ask that the test be stopped at any time.

Mild lightheadedness and even fainting may occur. There is also a risk of cardiovascular complications, such as abnormal blood pressure, a heart attack or even death. Every effort has been made to minimize these risks by evaluating your health history form. If you have health conditions, please advise prior to the assessment.

I,_____, have enrolled in a program of mild to strenuous physical activity including but not limited to cardiovascular training, weight training, and flexibility training offered by the Department of Campus Recreation. I hereby affirm that I am in good physical condition and do not suffer from any disability which would prevent or limit my participation in this exercise program. I further affirm that I have had ample opportunity to consult with a physician of my choice before participating in this program.

In consideration of my participation in the Department of Campus Recreation's exercise programs, I, _____ for myself, my heir and assigns, hereby release Stony Brook University, the State of New York, the State University of New York and the Department of Campus Recreation's employees from any claim, demands and cause of action arising from my participation in the Department of Campus Recreation's exercise program.

I fully understand that I may injure myself as a result of my participation in the Department of Campus Recreation's exercise program and I,_____, hereby release Stony Brook University, the State of New York, the State University of New York and the

Department of Campus Recreation from any liability now or in the future including, but not limited to heart attacks, muscle strains, pulls or tears, broken bones, shin splints, heat prostration, injuries to knee, lower back, foot and any other nausea, faintness, fatigue, illness, damage, soreness or injury however caused, occurring during, or after my participation in the exercise program.

My questions have been answered concerning the fitness assessment. I am aware that unforeseen complications may arise during these activities. I agree to assume full responsibility for my participation and hereby consent to participate.

I have read and understand the aforementioned statements.

Print Name	Signature
Date	Witness

PAR Q & YOU

NAME: _____ ID #: _____

Regular physical activity is fun and healthy, and increasingly more people are starting to become more active every day. Being more active is very safe for most people. However, some people should check with their doctor before they start becoming much more physically active.

If you are planning to become much more physically active then you are now, start by answering the seven questions in the box below. If you are between the ages of 16 and 59, the Par-Q will tell you if you should check with your doctor before you start. If you are over 59 years of age, and you are not used to being very active, check with your doctor.

Common sense is your best guide when you answer these questions. Please read the questions carefully and answer each one honestly. Check YES or NO.

YES/NO

☐ ☐ 1. Has your doctor ever said you have a heart condition, and that you should only do physical activity recommended by a doctor?
☐ ☐ 2. Do you feel pain in your chest when you are physically active?
☐ ☐ 3. In the past month, have you had chest pain when you were not doing physical activity?
☐ ☐ 4. Do you lose your balance because of dizziness or have you ever lost consciousness?
☐ ☐ 5. Do you have a bone or joint problem that could be made worse by a change in your physical activity (i.e. chronic back pain, past surgeries)?
☐ ☐ 6. Is your doctor currently prescribing any drugs (i.e. for a blood pressure or heart condition) that may affect your ability to be physically active?
☐ ☐ 7. Do you know of any other reason why you should not do physical activity?

If you answered YES to ANY QUESTION

Talk with your doctor by phone or in person before you start becoming much more physically active before you have a fitness appraisal. Tell your doctor about the PAR-Q and which question(s) you answered YES.

- You may be able to do any activity you want as long as you start slowly and build up gradually. Or, you may need to restrict your activities to those, which are safe for you. Talk with your doctor about the kinds of activities you wish to participate in and follow his/her advice and have them complete the PHYSICIAN'S APPROVAL FORM.
- Find out which community programs are safe and helpful for you.

If you answered NO to all questions

- If you answered NO honestly to all PAR-Q questions, you can be reasonably sure you can:
- Start becoming much more physically active, begin slowly and build up gradually. It's the safest and easiest way to.
- Take part in a physical appraisal - this is an excellent way to determine your basic fitness so that you can plan the best way for you to live actively.

Delay becoming much more active if:

- If you are not feeling well because of a temporary illness such as a cold or fever – wait until you feel better.
- If you are pregnant – talk to your doctor and have them complete the PHYSICIAN'S APPROVAL FORM before you start becoming more active.
- Please note: If your health changes so that you then answer YES to any of the above questions, tell your fitness or health professional.

I have read, understood and completed the questionnaire.

Name: _____ Date: _____

PHYSICIAN'S APPROVAL FORM

_____ has medical approval to participate in fitness programs and in the use of the exercise equipment at various sites, including home or office, that may be provided by and/or recommended by the Personal Trainers, Campus Recreation, Stony Brook University. The following restrictions apply (if none, so state):

_____

Physician's signature Physician's name (please print)

Address: _____ Phone: _____

Name _____ Section _____ Date _____

LAB 9.3 *Checking for Body Image Problems and Eating Disorders*

Assessing Your Body Image

	Never	Sometimes	Often	Always
1. I dislike seeing myself in mirrors.	0	1	2	3
2. When I shop for clothing, I am more aware of my weight problem, and consequently I find shopping for clothes somewhat unpleasant.	0	1	2	3
3. I'm ashamed to be seen in public.	0	1	2	3
4. I prefer to avoid engaging in sports or public exercise because of my appearance.	0	1	2	3
5. I feel somewhat embarrassed about my body in the presence of someone of the other sex.	0	1	2	3
6. I think my body is ugly.	0	1	2	3
7. I feel that other people must think my body is unattractive.	0	1	2	3
8. I feel that my family or friends may be embarrassed to be seen with me.	0	1	2	3
9. I find myself comparing myself with other people to see if they are heavier than I am.	0	1	2	3
10. I find it difficult to enjoy activities because I am self-conscious about my physical appearance.	0	1	2	3
11. Feeling guilty about my weight problem preoccupies most of my thinking.	0	1	2	3
12. My thoughts about my body and physical appearance are negative and self-critical.	0	1	2	3
Now add up the number of points you have circled in each column: ____	0	+____	+____	+____

Score Interpretation

The lowest possible score is 0, and this indicates a positive body image. The highest possible score is 36, and this indicates an unhealthy body image. A score higher than 14 suggests a need to develop a healthier body image.

SOURCE: Nash, J. D. 1997. *The New Maximize Your Body Potential*. Palo Alto, Calif.: Bull Publishing. Reprinted with permission of the publisher.

Eating Disorder Checklist

	Always	Very Often	Often	Sometimes	Rarely	Never
1. I like eating with other people.	0	0	0	1	2	3
2. I like my clothes to fit tightly.	0	0	0	1	2	3
3. I enjoy eating meat.	0	0	0	1	2	3
4. I have regular menstrual periods.	0	0	0	1	2	3
5. I enjoy eating at restaurants.	0	0	0	1	2	3
6. I enjoy trying new rich foods.	0	0	0	1	2	3
7. I prepare foods for others, but do not eat what I cook.	3	2	1	0	0	0
8. I become anxious prior to eating.	3	2	1	0	0	0
9. I am terrified about being overweight.	3	2	1	0	0	0
10. I avoid eating when I am hungry.	3	2	1	0	0	0
11. I find myself preoccupied with food.	3	2	1	0	0	0.
12. I have gone on eating binges where I feel that I may not be able to stop.	3	2	1	0	0	0
13. I cut my food into small pieces.	3	2	1	0	0	0

	Always	Very Often	Often	Sometimes	Rarely	Never
14. I am aware of the calorie content of foods that I eat.	3	2	1	0	0	0
15. I particularly avoid foods with a high carbohydrate content (bread, potatoes, rice, etc.).	3	2	1	0	0	0
16. I feel bloated after meals.	3	2	1	0	0	0
17. I feel others would prefer me to eat more.	3	2	1	0	0	0
18. I vomit after I have eaten.	3	2	1	0	0	0
19. I feel extremely guilty after eating.	3	2	1	0	0	0
20. I am preoccupied with a desire to be thinner.	3	2	1	0	0	0
21. I exercise strenuously to burn off calories.	3	2	1	0	0	0
22. I weight myself several times a day.	3	2	1	0	0	0
23. I wake up early in the morning.	3	2	1	0	0	0
24. I eat the same foods day after day.	3	2	1	0	0	0
25. I think about burning up calories when I exercise.	3	2	1	0	0	0
26. Other people think I am too thin.	3	2	1	0	0	0
27. I am preoccupied with the thought of having fat on my body.	3	2	1	0	0	0
28. I take longer than others to eat my meals.	3	2	1	0	0	0
29. I take laxatives.	3	2	1	0	0	0
30. I avoid foods with sugar in them.	3	2	1	0	0	0
31. I eat diet foods.	3	2	1	0	0	0
32. I feel that food controls my life.	3	2	1	0	0	0
33. I display self-control around foods.	3	2	1	0	0	0
34. I feel that others pressure me to eat.	3	2	1	0	0	0
35. I give too much time and thought to food.	3	2	1	0	0	0
36. I suffer from constipation.	3	2	1	0	0	0
37. I feel uncomfortable after eating sweets.	3	2	1	0	0	0
38. I engage in dieting behavior.	3	2	1	0	0	0
39. I like my stomach to be empty.	3	2	1	0	0	0
40. I have the impulse to vomit after meals.	3	2	1	0	0	0
Now add up the number of points in each column for statements 1 through 40:____	____+	____+	____+	____+	____+	____

Score Interpretation

The possible range is 0–120. A score higher than 50 suggests an eating disorder. A score between 30 and 50 suggests a borderline eating disorder. A score less than 30 is within the normal range. Among those with normal eating habits, the average score is 15.4.

SOURCE: Nieman, D. 1999. *Exercise Testing and Prescription: A Health-Related Approach,* 4th ed. Mountain View, Calif.: Mayfield. Reproduced with permission from The McGraw-Hill Companies.

Using Your Results

How did you score? Are you surprised by your scores? Do the results of either assessment indicate that you may have a problem with body image or disordered eating?

What should you do next? If your results are borderline, consider trying some of the self-help strategies suggested in the chapter. If body image or disordered eating is a significant problem for you, get professional advice; a physician, therapist, and/or registered dietitian can help. Make an appointment today.

Health History

Client Information: Date: _____

First Name: _____ Last Name: _____
Age: _____ Date of Birth: ___/___/___ Gender: _____
Preferred Contact Phone #: _____
Permanent Address E-mail Address: _____
_____
_____
_____
Physician's Name: _____ Physician's Number:_____

Personal Medical History:
Past Operations:
_____
_____
_____
_____

Hospitalizations:
_____
_____
_____
_____

Disabilities:
_____

Diseases:
_____
_____

Are you currently under a physician's care? Yes or No

Height: _____ Weight: _____ Desired Weight: _____

Personal Medical History (cont'd)
Have you ever been diagnosed with the following? Please check all that apply.

Date & Description

_____ Heart Attack _____

_____ High Blood Pressure _____

_____High Cholesterol _____

_____High Blood Triglycerides _____

_____Rheumatic Fever _____

_____Heart Murmur _____

_____Seizure/Epilepsy _____

_____Stroke _____

_____Abnormal Electrocardiogram _____

_____Blood Clots _____

_____Cancer _____

_____Diabetes _____

_____Asthma _____

_____Exercise-Induced Asthma _____

_____Arthritis _____

_____Osteoporosis _____

_____Gout _____

_____Thyroid Disorders _____

_____Allergies _____

_____Varicose Veins _____

_____Hernia _____

_____Obesity _____

_____Anorexia _____

_____Bulimia _____

_____Severe Headaches _____

_____Kidney Failure _____

_____Kidney Removal _____

_____Kidney Stones _____

_____Kidney Dialysis _____

_____Gall Bladder Removal _____

_____Gall Bladder Disease/Stones _____

_____Colitis _____

_____Fibromyalgia _____

_____Anemia _____

_____Pregnancy _____

Medications

Please check all that apply, provide the name and describe side effects, if any.

_____Anti-Arrhythmias _____

_____Alpha Blockers _____

_____Anti-Inflammatory (Motrin, Advil) _____

_____Beta Blockers _____

_____Calcium Channel Blockers _____

_____Cholesterol _____

_____ Digitalis _____

_____Diuretics & Electrolytes _____

_____Metabolics (Insulin, Thyroid) _____

_____Tranquilizers or Sedatives _____

_____Vasodilators _____

_____Other _____

Injury History

Have you ever suffered an injury at any of the following joints? If so, please describe the severity and frequency.

Ankle (R or L):

_____

Knee (R or L):

_____

Shoulder (R or L):

_____

Neck:

_____

Hip:

_____

Back:

_____

Other:

_____

Do any of the joints above bother you during exercise? _____

If yes, please explain: _____

_____

_____

Family History

Please check if anyone in your immediate family (grandparents, parents and/or siblings) have experienced the following.

Relationship Age Description

_____Heart Attack or Stroke before the age of 55 _____

_____Heart Surgery _____

_____High Cholesterol _____

_____High Blood Pressure _____

_____High Blood Triglycerides _____

_____Diabetes _____

_____Cancer _____

_____Alzheimer's _____

_____Heart operations _____

_____Congenital Heart Disease _____

_____Early death _____

_____Other _____

_____Other _____

_____Other _____

Symptoms

Have you ever experienced any of the following during a resting state, during exercise or after exercise? Check all that apply.

_____Shortness of breath or wheezing	_____Side aches/stitches	_____Middle back pain
_____Extremely high heart rate	_____Sharp chest pain	_____Low back pain
_____Irregular heart rate	_____Dull, aching chest pain	_____Foot/ankle pain
_____Heat intolerance	_____Loss of coordination	_____Knee pain
_____Overall/One-sided weakness	_____Dizziness	_____Shoulder pain
_____Mental Confusion	_____Fainting	_____Arm/neck pain
_____Vomiting	_____Swelling of ankles/hands	_____Hip pain/Sciatica
_____Cramping	_____Shin splints	_____Calf pain

Lifestyle

Please check all that apply.

Do you smoke? _____Yes _____No

If yes, please select from the following: _____Cigarettes _____Cigar _____Pipe

How many do you smoke per day? _____

How many years have you smoked? _____

Are you a former smoker? _____Yes _____No

If yes, how long ago did you stop smoking? _____

Do you drink alcoholic beverages? _____Yes _____No

If yes, how much do you drink (in ounces) in an average week? _____

Do you drink caffeinated beverages? _____Yes _____No

If yes, how many cups per day? _____

Please rate your daily level of stress:

_____Low _____High & sometimes difficult to handle

_____Moderate _____High & often difficult to handle

_____High, but I enjoy the challenge

Lifestyle cont'd

Please describe what you eat on a typical day and give specific examples. (Give an approximate time of when you eat each)

Breakfast:

_____

_____

Lunch:

_____

_____

Dinner:

_____

_____

Other:

_____

_____

Exercise Habits:

How many times per week are you physically active? _____

When you are physically active, how long does it last? _____

On a scale from 1 to 10, how intense is your typical activity (10 being highest) _____

How many years have you been exercising? _____

In a typical week, how many minutes do you spend in the following activities?

_____ Running/jogging	_____ Racquet sports	_____ Pilates
_____ Walking	_____ Skiing	_____ Stair Climbing
_____ Biking	_____ Aerobics	_____ Weight Training
_____Swimming	_____ Yoga	

Other:

_____

Emergency Contact Information:

Name: _____ Relationship:_____

Phone Number:_____

FOR OFFICE USE ONLY

Date Received: _____ Participant Contacted: _____

Date/Method of Payment: _____ CASH CHECK Participant Accepted: YES NO

Participant Referred to: _____

Before submitting this application, please make sure the following is included:

- Completed participant application
- Typed Essay (3 paragraph minimum.)
- Liability & Informed Consent
- Physical Activity Readiness Questionnaire (PAR-Q)
- Eating Attitudes Test
- Health History Form
- Physician's clearance form (if necessary)

Questions can be directed to:
Dean Bowen
Student Activities Center Room 225
dean.bowen@stonybrook.edu
631-632-7263

Activity Log

Record information about the physical activities you do each day for one week.

Week of: _____

DAY	ACTIVITY DESCRIPTION	DURATION	MISC
example	**Running- Treadmill**	**40 minutes**	**Heart Rate, Calories etc**
example	**Group Fitness Class**	**55 minutes**	**Used Weights, Balls etc**
Monday			
Tuesday			
Wednesday			
Thursday			
Friday			
Saturday			
Sunday			

Food Journal

Record information about the foods you consume each day for one week. Use the Campus Dining web Site for additional help in this activity (www.campusdining.org, click on Nutrition).

Week of: _____

DAY	TIME	WHAT	SERVING	CALORIES	MISC
example	**7:30am**	**Whole Wheat Bagel**	**1 Whole**	**245**	**Toasted w/ butter**
example	**12:00pm**	**Cheese Pizza**	**1 Slice**	**440**	**w/ water**
example	**5:00pm**	**Chef Salad**	**2 Cups**	**259**	**w/ lt. Italian**
Monday					
Tuesday					
Wednesday					
Thursday					
Friday					
Saturday					
Sunday					

Resource Guide:

If you are not accepted to be involved with the Stony Brook Fit Club the following resources are still available for you on the Stony Brook Campus…

The Department of Campus Recreation www.recreation.sunysb.edu

- Intramural
- Sport Clubs
- Open Recreation
- Group Fitness Classes
- Personal Training
- Wellness Center
- Special Events

Wellness Office 632-6850, SAC 225
Main Office 632-7168, Sports Complex G-7

Employee Assistance Program (EAP) www.stonybrook.edu/eap

- Clinical Consultation
- Management Consultation
- Education & Training
- Critical Incident Stress Debriefing (CISD)
- Organizational Consultation

West Campus, 192 Administration
East Campus Rm 556, Level 5 HSC

Student Health Services http://studentaffairs.stonybrook.edu/shs/

- Medical Clinic: 632-6740
- Women's Clinic: 632-6740
- Social Worker: 632-6740
- Drug/Alcohol Counselor: 632-6450
- Health Educators: 632-6689 / 632-9338
- Pharmacy: 632-6804
- Student Health Service Laboratory: 632-0319
- Nutrition: 632- 6740
- Counseling Center: 632-6720
- Ambulance Corps: 632-3333
- University Police: 632-3333
- Student Health Insurance: 632-6054
- Foreign Student Insurance: 632-7040
- Graduate Student Employee Health Insurance: 632-6144

1 Stadium Road
Across from Mendelsohn Quad

Center for Prevention and Outreach (CPO) http://studentaffairs.stonybrook.edu/cpo/index.shtml

- Assistance with Substance Abuse, Depression, Sexual Assault & Health Education
- For a full list of resources please visit http://studentaffairs.stonybrook.edu/cpo/CPO_resources.pdf

Campus Dining Services http://campusdining.org/index.php

- Menus of all Campus Dining Centers
- Hours of Locations/Dining Centers
- Nutrition Detail