Wellness Center 55 Plus Health Information

GENERAL INFORMATION
(Please PRINT Legibly)

Date:_____

Full Name:

_____

Check all that apply: ( ) Bariatric
( ) 55 Plus ( ) SilverSneakers
( ) Volunteer ( ) Thriver/Cancer
( ) Cardiac/Pulmonary Rehab

Date of Birth: _____
( ) Male ( ) Female

Mailing Address:

_____
Street

_____
City State Zip

Cell or Home#:_____

Email:_____

Name of Physician:

_____

Physician's Phone:

(___)_____

MEDICAL HISTORY

Do you have high blood pressure?

- ❑ **NO**
- ❑ **YES, medication?** _____

Does medication control BP? Yes No

Have you ever had any of the following conditions with your heart? (Check all that apply)

- ❑ **Heart Attack-Date:** _____
- ❑ **Heart Surgery-Date:** _____
- ❑ **Angina-Date:** _____
- ❑ **Rapid or irregular heart rate-Date:** _____

NEW MEMBERS:
Please list hospitalizations for surgical operations and/or serious illness _____
_____
_____
_____
_____
_____

RETURNING MEMBERS:
Have you been hospitalized for any surgical operations or serious illness in the past year?

- ❑ No
- ❑ Yes;
  Explain:_____
  _____
  _____

List medications or attach list of medications:
_____
_____
_____
_____
_____
_____
_____

How did you hear about us? _____
_____

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Personal Health History (Please answer all questions. Explain all "YES" answers.)

Have you had?	YES	NO
Asthma		
Arthritis		
Back/Neck problems		
Blood clots		
Chest pain/Discomfort		
Cholesterol problems		
Diabetes		
Difficulty breathing		
Fainting/Dizziness		
Headaches		
Head injury		
Heart murmur		
Heart palpitation		
Irregular heart beat		
Joint problems		
Joint replacements/Implants		
Muscle pain		
Muscle weakness		
Problems with falling		
Pacemaker		
Stroke		

Explain all "YES" answers below:_____

_____

_____

_____

_____

Do you suffer from any of the following **during** physical activity?

	YES	NO
Back/neck pain		
Drop in blood pressure		
Falling		
Heart palpitations		
Joint pain		
Pain/discomfort in the chest		
Pain/discomfort in the legs causing you to stop walking		
Shortness of breath		
Unexplained dizziness/fainting		

Family History

Have any of your blood relatives had any of the following problems?

- ❑ Heart disease; you or relative?_____
- ❑ Diabetes; you or relative? _____
- ❑ Cancer; you or relative? _____
- ❑ Lung Disease? _____
- ❑ Arthritis?_____
- ❑ Obesity?_____
- ❑ Stroke?_____
- ❑ High Blood Pressure?_____

NEW MEMBERS ONLY:

Describe any regular physical activity or exercise program that you take part in.

Type of exercise:_____

_____

_____

Frequency:_____

_____

_____

Duration:_____

_____

_____

Intensity:_____

_____

Please tell us about your fitness goals:

_____

_____

_____

_____

Are there any other factors or conditions the staff should be aware of before participating in our program?

_____

_____

_____

_____

RETURNING MEMBERS ONLY:

Have you ever referred a new member to us?

- ❑ Yes
- ❑ No

Wellness Center Assumption of Risk and Release of Liability for Members

Print Name_____

I understand and am aware that strength, flexibility, and various activities and exercises, including the use of equipment is potentially hazardous. I also understand that fitness activities involve a risk of injury and even death. I hereby agree to expressly assume and accept any and all risks of injury or death that may result from my participation in this activity. I understand that I am responsible for my own safety, health, and welfare during this activity.

I acknowledge that it is my obligation to ensure my participation in or use of any of the Memorial Health System Wellness Center activities, facilities, equipment, or machinery is consistent with any physical limitations I may have, and to consult with a physician to ensure that I am medically able to participate in these activities. I do hereby assume full responsibility for my participation and use of any of the Memorial Health System Wellness Center activities, facilities, equipment, and machinery.

In consideration of being allowed to participate in the activities and programs of the Memorial Health System Wellness Center, and to use its facilities, equipment, and machinery in addition to the payment of any fee or charge, I do hereby waive, release and forever discharge the Memorial Health System and their respective officers, employees, agents and all others from any and all liability, claims, demands, causes of action, injuries, damages, or losses resulting from my participation in any activities or my use of equipment or machinery in the Memorial Health System Wellness Center or arising out of my participation in any activities at the Memorial Health System Wellness Center.

I agree to abide by all policies and procedures set forth by the Memorial Health System Wellness Center. I further affirm that I have had the opportunity to ask questions and any questions I have asked have been answered to my complete satisfaction. I understand and agree that this Assumption of Risk and Waiver of Liability will be held on file for the duration of my membership. I understand and agree that if any part of this Assumption of Risk and Release of Liability is for any reason found to be invalid or unenforceable, the remaining provisions shall remain in full force and effect.

My signature indicates that I have read, understand, and agree that this is an assumption of risk and a waiver of any and all claims or causes of action, which I may have or might accrue as a result of my participation in or use of the Memorial Health System Wellness Center activities, facilities, equipment or machinery. Please read this entire document carefully before signing. This releases the Memorial Health System from any liability resulting from my participation in the above-described Memorial Health System Wellness Center sponsored programs.

Signature _____ Date_____

In case of emergency, contact: _____

Phone Number: (___)_____ Relationship: _____

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❑ **New Member**
❑ **Past or Returning Member**

Wellness Center Medical Clearance

Dear Doctor _____,

_____ _____ _____
(Name) (Phone #) (DOB)
wishes to take part in an exercise/fitness program. The exercise program may include progressive resistance training, flexibility exercises, and a cardiovascular program; increasing in duration and intensity over time.

By completing this form, you are not assuming any responsibility for our exercise and assessment program. Please identify any recommendations or restrictions for your patient's fitness program below.

❑ I am not aware of any contraindications toward participation in a fitness program.
❑ I believe the applicant can participate, but I urge caution because: _____
_____
_____

❑ The applicant should **not** engage in the following activities: _____
_____
_____

❑ I recommend the applicant **not** participate in the above fitness program.

❑ If your patient is taking medications that will affect their response to exercise, please indicate the manner of the effect. Type of medication: _____
_____

Physician's Signature: _____ Date: _____

Physician's Name (Please Print): _____ Phone: _____

*Please direct any questions to:

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Marietta, OH 45750
Phone: (740) 568-5380
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