



Health Status Questionnaire

Membership Type _____

Guest Fee _____

Assessment Fee Yes No

General Training Yes No

Contract Expiration Date _____

We require all program participants to fill out this questionnaire truthfully and completely to help us determine if you are ready to exercise and/or if you require a physician's consent to exercise. This questionnaire is in accordance to the standards of care for fitness facilities advocated by the American Heart Association and the American College of Sports Medicine.

Name (Printed) _____

Today's Date _____

Address _____ City _____ State _____ Zip _____

Daytime Phone _____ Date of Birth _____ Email Address _____

Part One:

If you answer Yes to either #1, #2 or #3 below, we will require a physician's clearance for you to participate in the program. This allows input from your physician.

- 1. Has your doctor ever told you that you have heart disease (specifically heart attack, heart bypass surgery, leg bypass surgery, congestive heart failure, and/or angina/chest pain?)
 Yes No
- 2. Has a doctor ever told you that you have diabetes? Yes No
- 3. Are you pregnant? Yes No



If you answered YES to any questions in Part One.

Part Two:

If you answer YES to two or more statements below, we will require one of our fitness staff to review your responses and determine if a physician's clearance is required. If you do not know the answers to some of these questions, the fitness staff will go over this with you.

- Yes No You are older than 55, or have had a hysterectomy or are postmenopausal.
- Yes No You smoke or quit smoking within the past six months.
- Yes No Your blood pressure is greater than 140/90 mmHg.
- Yes No Your blood cholesterol is greater than 200 mg/dl.
- Yes No You have a close blood male relative (father or brother) who had a heart attack or heart surgery before the age of 55 or a close female relative (mother or sister) who had a heart attack or surgery before the age of 65.
- Yes No You are physically inactive (you get less than 30 minutes of physical activity at least 3 times per week).
- Yes No Your waist circumference is greater than 35 inches.

Medical Clearance needed per Fitness Staff (Signature): _____ Date: _____

Fitness Staff Clearance (Signature): _____ Date: _____

Physician Clearance Process:

If you are required to have a physician's consent, you can choose one of the following (circle):

- 1. We will fax the form on your behalf and contact you when we receive it.
- 2. We will provide you with the form to mail or fax to your physician.

Part Three:

Answers to these questions below, may indicate you need a physician's clearance.

Do you have?

- 1. A rheumatoid condition, such as arthritis or fibromyalgia, that limits your ability to exercise (excluding osteoarthritis)?
 Yes No Describe: _____
- 2. A joint, back or neck injury that significantly limits your ability to exercise?
 Yes No Describe: _____
- 3. A respiratory diagnosis that significantly limits your ability to exercise?
 Yes No Describe: _____
- 4. Have you ever had a joint replacement? Yes No
 If yes, what joint(s) were replaced and when? _____
- 5. Have you ever had a stroke (including TIA)? Yes No
 If yes, when? _____
- 6. Have you ever had a spinal cord injury? Yes No
 If yes, when? _____
- 7. Do you have a diagnosed neurological condition? Yes No
 Describe: _____
- 8. Do you have balance problems that limit your ability to exercise? Yes No
- 9. Do you have a history of falling? Yes No
- 10. Do you use any assistive devices for walking or moving? Yes No
 Cane Walker Wheelchair Other _____

Referred to Clinical Staff Yes No Date of referral: _____

_____ **I have read, understood and completed the above questionnaire. Any questions I had were answered to my full satisfaction.**

Initials _____ ***Agreement and Release of Liability***

_____ In consideration of gaining membership or being allowed to participate in the activities and programs of Woman's Center for Wellness and to use its facilities, and equipment, in addition to the payment of any fee or charge, I do hereby waive, release and forever discharge the Woman's Center for Wellness and its officers, agents, employees, representatives, executors, and all others from any and all responsibilities or liability for injuries or damages resulting from my participation in any activities or my use of equipment in the above-mentioned facilities or arising out of my participation in any activities at said facility. I do also hereby release all of those mentioned and any others acting upon their behalf from any responsibility or liability for any injury or damage to myself, including those caused by the negligent act or omission of any of those mentioned or others acting on their behalf or in any way arising out of or connected with my participation in any activities of the Woman's Center for Wellness or the use of any equipment at the Fitness Club.

_____ I understand and am aware that strength, flexibility, and aerobic exercise, including the use of equipment, is a potentially hazardous activity. I also understand that fitness activities involve a risk of injury and even death and that I am voluntarily participating in these activities and used equipment with knowledge of the dangers involved. I hereby agree to expressly assume and accept any and all risks of injury or death.

_____ I do hereby further declare myself to be physically sound and suffering from no condition, impairment, disease, infirmity, or other illness that would prevent my participation in any of the activities and programs of the Wellness Center or use of equipment except as hereinafter stated. I do hereby acknowledge that I have been informed of the need for a physician's approval for my participation in an exercise/ fitness activity or in the use of exercise equipment and machinery. I also acknowledge that it has been recommended that I have a yearly or more frequent physical examination and consultation with my physician as to physical activity, exercise, and use of exercise and training equipment so that I might have recommendations concerning these fitness activities and equipment use. I acknowledge that I have either had a physical examination and have been given my physician's permission to participate, or that I have decided to participate in activity and/or use of equipment without the approval of my physician and do hereby assume all responsibility for my participation and activities, and utilization of equipment in my activities.

Signature _____ **Date** _____

Staff Witness _____