Woman's

Please check the program you are registering for:

☐ **Maniac** ☐ **Jump Start** ☐ **Jump Start Plus**

Health Status Questionnaire

We require all potential members and participants 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)_____ Signature_____Today's Date_____

Address_____ City_____ State_____ Zip_____

Daytime Phone_____ Date of Birth_____ Email Address_____

Emergency Contact_____ Phone_____

NOTE:

Maniac Participants MUST be able to:

- Perform either 5 standard push-ups or 10 modified push-ups.
- Perform a squat with good form.
- Tolerate jumping and high impact exercise.
- Have an exercise history of at least six months in continuous and challenging workouts.

In the event you cannot pass these requirements, we have other options, such as our Jump Start programs. There are no exceptions to these requirements due to the nature of the Maniac workout.

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:**_____

MEDICAL AND LIFESTYLE HISTORY

Instructions

Complete each question accurately. All information provided is confidential. In most cases, please check mark the correct answers. Only check those that apply.

1. Do you have a history of the following conditions, **medically diagnosed** by a physician or a healthcare professional? *Check all that apply.*

☐ Abnormal EKG or Chest x-ray	☐ Bronchitis, Chronic	☐ Cancer	☐ Hip Problems
☐ Cigarette Smoking	☐ Other Lung Disorders	☐ Hearing Loss	☐ Back Problems
☐ High Blood Pressure	☐ Anemia, blood disorder	☐ Vision Loss	☐ Shoulder Problems
☐ High Cholesterol	☐ Liver Disorder	☐ Mental Illness	☐ Neck Problems
☐ Diabetes	☐ Thyroid Disorder	☐ Osteoporosis	☐ Recent Broken Bones
☐ Peripheral Vascular Disease	☐ Kidney Disorders	☐ Osteopenia	☐ Swollen or Painful Joints
☐ Heart Attack or Stroke	☐ Hypoglycemia	☐ Urine Leakage	☐ Major Injury
☐ Irregular Heart Beat or Rhythm	☐ Eating Disorders	☐ Chronic Headaches	☐ Balance Problems
☐ Heart Condition	☐ Gout	☐ Phlebitis or Blood Clot	☐ History of Falling
☐ Heart Murmur	☐ Epilepsy or Seizures	☐ Congenital Defect	☐ Other_____
☐ Stroke	☐ Arthritis	☐ Rheumatic Fever	_____
☐ Emphysema	☐ Fibromyalgia	☐ Foot Problems	_____
☐ Asthma	☐ Hernia	☐ Knee Problems	

Has a doctor given you any activity restrictions? ☐ No ☐ Yes **If Yes, please describe:**_____

_____

2. ☐ Yes ☐ No Do you currently have an illness or infection? _____

3. ☐ Yes ☐ No Have you been hospitalized or had major surgery within the last year?

4. ☐ Yes ☐ No Are you pregnant or have you given birth within the last two months?

5. What operations have you had? Check all that apply and indicate date of operation.

☐ Back _____	☐ Eyes _____	☐ Heart_____	☐ Hysterectomy_____	☐ Lung _____	☐ Other_____
☐ Ears_____	☐ Joint _____	☐ Hernia_____	☐ Kidney ____	☐ Neck _____	_____

6. Have you experienced any of the following symptoms **during exercise or activity** (including walking, climbing, stairs, or working)?

☐ Chest Pain, Heaviness or Tightness	☐ Dizziness or Light-headedness	☐ Please Explain_____
☐ Extreme Breathlessness	☐ Mental Confusion	_____
☐ Rapid Heartbeats or Palpitations	☐ Low Back or Neck Pain	
☐ Shoulder or Arm Pain/Numbness	☐ Leg Pain or Cramping (claudication)	_____

7. Please select any medication or supplements you are currently using:

☐ Diuretics	☐ Nitroglycerin	☐ Herbs or Supplements
☐ Beta Blockers	☐ Cholesterol	☐ NSAIDS/Anti-inflammatory (Motrin®/Advil®)
☐ Vasodilators	☐ Calcium Channel Blockers	
☐ Alpha Blockers	☐ Diabetes/Insulin	☐ Pain Medication
☐ Other Cardiovascular Drugs	☐ Chemotherapy/Radiation	☐ Other Drugs_____
☐ Blood Thinners, Aspirin	☐ Antidepressants	_____

8. Please list the specific medication names that you are currently taking:_____
_____
_____

9. What is your height and weight?_____

10. On average, how many times are you physically active per week?_____

11. How long has it been since you last exercised regularly (2 – 3x per week)?_____

12. On average, how long do you exercise per session?_____

13. On a scale from 1 to 10, how intensely do you exercise?_____

Very Easily 1 2 3 4 5 6 7 8 9 10 *Very Intensely*

14. Which of the following activities do you like to do?

- ☐ Running / Jogging
- ☐ Walking
- ☐ Stair Climbing / Eliptical
- ☐ Bicycle / Spinning
- ☐ Strength Training
- ☐ Aerobic Classes
- ☐ Swimming
- ☐ Dancing
- ☐ Yoga / Martial Arts
- ☐ Golfing
- ☐ Gardening / Yard Work
- ☐ Bowling
- ☐ Rollerblading or Skating
- ☐ Other_____

15. ☐ Yes ☐ No Do you currently smoke? How long have you smoked?_____

How long has it been since you quit?_____

16. ☐ Yes ☐ No Do you drink caffeinated beverages? How much caffeine do you drink?_____

17. Please rate your daily average stress level.

- ☐ Low
- ☐ Moderate
- ☐ High: I enjoy the challenge
- ☐ High: sometimes difficult to handle
- ☐ High: often difficult to handle

18. Please select the following dietary habits you regularly follow.

- ☐ I seldom consume red or high-fat meats.
- ☐ I pursue a low-fat diet.
- ☐ My diet includes many high-fiber foods.
- ☐ I eat at least 5 fruits/vegetables servings per day.
- ☐ I almost always eat a full, healthy breakfast.
- ☐ I rarely eat high-sugar or high-fat desserts.
- ☐ I take a multivitamin and mineral supplement.
- ☐ I pursue a high protein, low carbohydrate diet.

19. Please indicate any other medical conditions or activity restrictions that you may have that are not previously mentioned. *It is important that this information be as accurate and complete as possible.*

_____

_____

_____

I have read, understood and completed this questionnaire. I acknowledge, to the best of my ability, that I have answered the above questions completely and honestly. Any questions I had were answered to my full satisfaction.

_____ _____

Client Signature Date Staff Signature Date

_____ _____

Personal Representative's Signature Date Personal Representative's Relationship to Client

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 delcare 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 Fitness Club 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.

_____ I hereby give my consent to have photographs made of myself for purposes of promoting this program. I understand and agree that these images may be used by Woman's Hospital/Woman's Center for Wellness.

Signature _____ Date_____

Staff Witness_____