

Name (please print): _____
First MI Last

Address: _____
Street Address City/State Zip

Phone: _____
Home Work Cell

Email: _____ **Gender:** M F **Date of Birth:** _____

Employer: _____ **Occupation:** _____

Emergency Contact: _____
Name Relationship Phone

Primary Care Physician: _____
Name Phone

Specialist: _____
Name Phone

Y N Do you see and hear well? Please explain: _____

Y N Do you read/write English? If no, what language? _____

Y N Do you have any cultural or religious practices/beliefs that may affect your care or treatment?

If yes, please explain: _____

How did you hear about us?

- Physician Physical Therapy Friend/Member Cardiac/Pulmonary Rehab
- Health Fair/GHS Diabetes Clinic St. Vincent's Website Newspaper/Radio/Flyer
- Spouse Other: _____

Interests (Please check all that apply.)

- Arthritis Exercise Balance Aerobics (AM or PM) Water Aerobics
- Educational Classes Perinatal Pilates-Classes Tai Chi
- Swimming Lessons Weight Loss Pilates-Private Sessions Yoga
- Personal Training Other: _____

What do you wish to accomplish from your participation in the fitness program? (Please check all that apply.)

- Reduce Pain Improve Posture Increase Cardiovascular Endurance
- Increase Strength Prevent Surgery Walk Unassisted
- Increase Function Improve Flexibility Prepare for Surgery
- Return to Full Activity Lose Weight: _____ lbs Other: _____

Medical History (Please check all that apply.)

I have/have had this condition:

Medications

- Coronary heart disease_____
- Congenital heart disease_____
- Heart murmurs_____
- Angina (chest pains)_____
- Irregular heart beats_____
- Do you have a pacemaker?_____
- Valve problems_____
- Heart attack_____
- High blood pressure_____
- Mitral Valve Prolapse_____
- Stroke_____
- Diabetes_____
- Epilepsy_____
- Cancer - Type:_____
- Stomach ulcers_____
- Lung disease (COPD, asthma, emphysema...) - Please explain:_____
- Arthritis Type:_____ Where:_____
- Osteoporosis Hip Score_____ Spine Score_____
- Surgery within last 12 months - When and what type:_____
- Any chronic illness or condition - What type?_____
- Allergies - Please list:_____
- Do you think you may have an infection? - Please explain:_____
- Hernia (or any condition which may be aggravated by lifting weights)_____
- Do you currently smoke?_____
- Are you a previous smoker?_____
- Are you pregnant?_____
- Memory Loss, Alzheimer's, Dementia_____
- Other – Please Explain:_____

Nutrition (Please check all that apply.)

- I eat out less than 3 times per week.
- I rarely eat snacks between meals.
- I eat 3 meals per day
- I seldom eat fried foods or foods high in fat.
- I seldom eat sweets or junk food.
- I eat 3-5 fruits and vegetables daily.
- I seldom eat red meats.
- I drink at least 48 ozs of water daily

General Well Being (Please check all that apply.)

- I receive strength from my spiritual beliefs.
- I am concerned for my health but generally feel in good spirits most of the time.
- I feel that my life is a blessing.
- I have experienced insomnia.

Please rate your current activity level: (Over the last 6 months)

- None** (No exercise activity)
- Light** (Slow walking, limited activity, non-structured)
- Moderate** (Walk 10-20 minutes, 2-3 times per week, some structured exercise, some weight training)
- Heavy** (Walk 30-40 minutes, 3-4 times per week, structured exercise, weight training)

Possible Orthopedic Limitations to exercise (Please Check All That Apply & List Type of Injury)

- Neck _____
- Back _____
- Hip _____
- Knee _____
- Ankle _____
- Shoulder _____
- Elbow _____
- Wrist _____
- Hand _____
- Foot _____

For Office Use Only:

Join Date: _____ Member # _____ Spouse _____

Form of Payment: Auto Bankdraft 6-Month/12-Month Payment Payroll Deduction

Monthly Fee \$ _____ 1st Month Fee \$ _____ Initiation Fee \$ _____ Total \$ _____ Paid \$ _____

Cash: Receipt # _____ Check # _____ Membership Type: _____

Notes: _____

Staff

AGREEMENT AND RELEASE OF LIABILITY

1. In consideration of gaining membership or being allowed to participate in the activities and classes of the *St. Vincent's Hospital Fitness and Wellness Program* 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 *St. Vincent's Hospital* 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 or machinery 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 or others acting on their behalf or in any way arising out of or connected with my participation in any activities of the *St. Vincent's Hospital Fitness and Wellness Program* or the use of any equipment at the *St. Vincent's Bruno Rehabilitation Center*.

Please Initial _____

2. 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 using equipment and machinery with knowledge of the dangers involved. I hereby agree to expressly assume and accept any and all risks of injury or death. I understand that my participation in and use of these activities, machines and equipment is contingent upon my ability to independently, safely and correctly perform prescribed exercises as reviewed by a *St. Vincent's Hospital Fitness and Wellness Program* professional. I understand and accept that it is my responsibility to inform the *St. Vincent's Hospital Fitness and Wellness Program* staff of significant changes in my health & medical condition as it relates to exercise. I acknowledge and agree that in the event my health and/or medical condition changes, and in any way prevents me from performing prescribed exercises safely and correctly, at that time, my exercise program may be limited, restricted or eliminated completely at the evaluation and judgment of a *St. Vincent's Hospital Fitness and Wellness Program* professional.

Please Initial _____

3. I do hereby acknowledge that I have been informed of the need for a physician's approval for my participation in any of the activities and programs of the *St. Vincent's Hospital Fitness and Wellness Program* or use of equipment or machinery except as hereinafter stated. I also acknowledge that it has been recommended that I have a yearly and 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 a physician's permission to participate, or that I have decided to participate in activity and/or use of equipment and machinery without the approval of my physician and do hereby assume all responsibility for my participation and activities, and utilization of equipment and machinery in my activities.

Please Initial _____

Signature

Date

Witness

Date