

ABOUT YOU

MUST BE COMPLETED BY EACH PERSON ON MEMBERSHIP



Date Completed		Main Member Name / Membership#	
FIRST NAME		LAST NAME	BIRTH DATE:
<input type="checkbox"/> YOUTH (12 years or younger)		<input type="checkbox"/> TEEN (13-15 years)	<input type="checkbox"/> ADULT (16 years or older)
TELEPHONE		EMAIL	

ACTIVITY LEVEL

How many days a week do you usually get 30 minutes or more of exercise/physical activity? None 1 2 3 4 5 6 7

How intense is your activity? Easy Moderate Difficult

OVERALL HEALTH LEVEL

How would you rate your current level of health? Poor Fair Good Excellent

SERVICE & ACTIVITY INTERESTS **HEALTH HISTORY**

In what services, programs or activities do you have an interest?

HEALTH & FITNESS

Fitness Floor Orientation FREE

Group Fitness FREE

Incentive Program FREE

Personal Training

Pilates Personal Training

Youth Group Training

Health Screenings

Nutritional Counseling

Health Coaching

RELAXATION

Massage Therapy

Other: _____

SPORTS & RECREATION

Sport Leagues

Racquetball-Private Lessons

Squash-Private Lessons

Triathlon Training

Swimming-Private Lessons

Recreation Trips

Sports Conditioning Clinics

Tennis-Private Lessons

Youth Summer Camps

Youth Tennis Program

Youth Swimming

DO YOU HAVE A HISTORY OF ANY OF THE FOLLOWING CARDIAC, METABOLIC, OR PULMONARY CONDITIONS?

Yes No Diagnosed high blood pressure (on 2 separate checks)

Yes No Coronary angioplasty or cardiac surgery

Yes No Heart disease, heart attack, angina

Yes No Heart murmur

Yes No Peripheral vascular disease

Yes No Stroke

Yes No Diabetes

Yes No Kidney disease

Yes No Chronic bronchitis

Yes No Emphysema or chronic obstructive pulmonary disease (COPD)

Yes No Other Cardiac, Metabolic or Pulmonary Conditions:

DO YOU CURRENTLY HAVE ANY OF THE FOLLOWING SIGNS, SYMPTOMS, OR CONDITIONS?

SOME CONDITIONS MAY REQUIRE A MEDICAL CONSULTATION.

Yes No Ankle swelling

Yes No Chest pain (at rest or exertion)

Yes No Dizziness/fainting

Yes No Rapid heartbeats or palpitations

Yes No Shortness of breath (at mild exertion/rest)

Yes No Unexplained fatigue (unusual fatigue or shortness of breath with usual activities)

Yes No WOMEN: Are you pregnant?

Yes No Chronic back problems

Yes No Arthritis - Please explain: _____

Yes No Orthopedic problems - Please explain: _____

Yes No Major surgery or hospitalization within the past six months. Please explain: _____

Yes No Other medical restrictions. Please explain: _____

According to the American College of Sports Medicine (ACSM) any individual marking "YES" to one or more of the items on this form are required to obtain a personal physician's consent prior to starting an exercise program.

I verify I have answered these questions truthfully and to the best of my knowledge. I do hereby further declare that:

A I am 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 Solana Club or use of the equipment or machinery.

B I marked "YES" to one or more questions and therefore will obtain a release from my physician prior to participating in any activities at The Solana Club.

C I do acknowledge that I either had a physical examination and I have been given my 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 responsibilities for my participation and for the utilization of equipment and machinery in my activities.

DO YOU CURRENTLY HAVE ANY OF THE FOLLOWING CORONARY RISK FACTORS?

Yes No Female, age 55 or older

Yes No Male, age 45 or older

Yes No Smoking habit (within past six months)

Yes No Family history of heart disease (parents/siblings before age 55)

Yes No Sedentary lifestyle (inactive job with no regular exercise program; active less than 3 times per week; or no recreational pursuits)

LIST ALL MEDICATIONS YOU ARE TAKING-PRESCRIPTION AND OVER-THE-COUNTER:

Medications: _____ Reason for medications: _____

If I have a change in my health status during the course of my exercise program, I will notify the staff immediately.

Signature X	Date
Signature of parent or guardian if participant under 16	Parent or guardian name (please print)

REVIEW DATE	CHANGES	IF YES, DESCRIBE CHANGES BELOW:	STAFF INITIALS
	<input type="checkbox"/> Yes <input type="checkbox"/> No		
	<input type="checkbox"/> Yes <input type="checkbox"/> No		

NOTE: If changes are indicated, the participant (and physician, if necessary), should complete a new form before retesting.

FITNESS DEPARTMENT USE ONLY

Reviewed by: _____ Date: _____ Notes: _____