WakeMed
Healthworks Fitness & Wellness Center

# Health History Screening Questionnaire

| Name | | Phone Number | |
|---|---|---|---|
| Birthdate | Age | Height | Weight |
| Physician Name | Physician Practice | Physician Phone Number | |

***Physician approval may be required prior to starting membership***

**Please read each question below carefully and check the appropriate answer box honestly.**

| Question | YES | NO |
|---|---|---|
| 1.) Are you age 40 or older? | | |
| 2.) Do you smoke ten or more cigarettes per day? | | |
| 3.) Do you have a family history of cardiovascular disease prior to age 55 in parents or siblings? Circle type: Heart disease, heart event, stroke | | |
| 4.) Has a doctor ever told you that you have high blood pressure? | | |
| **5.) Do you lose consciousness/get dizzy?** | | |
| 6.) Do you experience discomfort in breathing while lying down or wake up suddenly gasping for air? | | |
| 7.) Do you experience chest pain? How often?: ______ | | |
| 8.) Do you experience seizures? How often?: ______ | | |
| 9.) Do you have cardiovascular disease (heart disease, stroke), or peripheral vascular disease? | | |
| 10.) Have you experienced a heart attack? When?: ______ | | |
| 11.) Do you have diabetes? | | |
| 12.) Do you have a chronic lung condition? Circle Type: Chronic bronchitis, asthma, COPD | | |
| 13.) Do you have any paralysis or current neuromuscular impairment due to a stroke, multiple sclerosis, lupus or other condition? | | |
| 14.) Have you ever/do you have a current or ongoing orthopedic problem? If "yes", please explain: ______ | | |
| 15.) Osteopenia and/or Osteoporosis? | | |
| **16.) Do you have a vision impairment? If "yes", please explain?: ______** | | |
| 17.) Have you been hospitalized or has your medical status changed in the past 6 months? Please specify: ______ | | |
| 18.) Have you had surgery within the past 6 months? Please specify: ______ | | |
| 19.) Do you currently have a hernia? | | |
| 20.) Are you currently under the care of a doctor for a specific medical condition? Please specify: ______ | | |
| 21.) Have you had abdominal surgery or hernia repair? Please specify: ______ | | |
| 22.) Do you have arthritis? If "yes", where?: ______ | | |
| **23.) Do you have a history of falls or have you experienced a recent fall?** | | |
| 24.) Do you experience difficulty with balance? | | |
| **25.) Do you use a device to assist with walking? Circle type: cane, walker, wheelchair** | | |
| **26.) Do you experience memory loss? Circle type: short-term, long-term** | | |

27.) Explain any current/past conditions or complications: ______

**Medications:**

| *Type* | *Frequency* | *Dosage* |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

***Official Use Only***

Your patient is interested in participating in the WakeMed Healthworks fitness program indicated below. S/he has provided us with health history information that may pose possible contraindications to his/her safe participation. **IF APPROPRIATE PLEASE SIGN AND DATE HERE.**

| PHYSICIAN'S NAME (PLEASE PRINT) | PHYSICIAN'S SIGNATURE | DATE |
|---|---|---|

____***General Membership*:** Independent use of cardiovascular and resistance training equipment and/or land based exercise classes with no supervision.
____***Personal Training, Personal Training Plus*:** One on one programming with a fitness specialist.
____***Safeway to Fitness*:** Supervised adult fitness program with blood pressure and heart rate monitoring, instructor led warm up and cool down.
____***SilverSneakers®/Silver&Fit®/Renew Active®*:** Independent use of exercise equipment and/or land based exercise classes with no supervision.
____***Transitional Exercise*:** Supervised small group exercise program for clients requiring on-going assistance with equipment set up. Participants must be able to transfer between equipment independently.

**IF NOT APPROPRIATE PLEASE SIGN AND DATE HERE:** ______
**Other recommendations/comments/concerns:** ______

**Healthworks Fitness & Wellness Center**

**3000 New Bern Avenue, Raleigh, NC 27610 / Phone: 919.350.8602 / Fax: 919.350.2969**

| NAME | Male Female<br>CIRCLE ONE | AGE | DATE OF BIRTH |
|---|---|---|---|

| HOME ADDRESS | CITY/STATE | ZIP CODE |
|---|---|---|

| HOME/CELL PHONE | WORK PHONE | EMPLOYER/DEPT | EMAIL ADDRESS |
|---|---|---|---|

| EMERGENCY CONTACT NAME | RELATIONSHIP | EMERGENCY CONTACT PHONE |
|---|---|---|

## Agreement and Release of Liability

In consideration of gaining membership and/or being allowed to participate in the activities and programs of Healthworks, WakeMed Health and Hospitals (hereby referred to as Healthworks), and to use its facilities, equipment and machinery in addition to the payment of any fee or charge, I hereby:

1. Understand and am aware that strength, flexibility and aerobic exercise, including the use of equipment and machinery, are potentially hazardous activities. 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 risk of injury or death.

___________ **(Initial)**

2. Agree that the answers and statements provided on this health history and screening questionnaire have been answered completely and accurately. I do hereby further declare that I have not withheld information regarding my physical soundness and any condition, impairment, disease, infirmity or other illness that would interfere with my safe and healthy participation in any of the activities and programs of Healthworks or use of equipment or machinery except as hereinafter stated. I understand that I have a continuing obligation to keep Healthworks informed of any changes in my health history status and understand that misinformation; false statements or failure to keep Healthworks informed of changes in my health status may result in revocation of this application or membership resulting herefrom. Further, I hereby assume all risk associated with my participation in the activities and services offered by Healthworks and in particular that resulting from any false information, misinformation or incomplete information that might be supplied regarding my safe and healthy participation in said activities and services.

___________ **(Initial)**

3. Acknowledge that I have been informed if there is a need for physician's approval for my participation in an exercise/fitness activity or program or in the use of exercise equipment or machinery based on the information provided. Further I acknowledge that I have either been informed that I have no need for physician approval at this time or that I have received physician approval to participate. I do hereby assume all responsibility and risk for my participation and activities, and utilization of equipment and machinery in my activities, regardless of what I am doing at the time of injury or damage.

___________ **(Initial)**

## Code of Conduct

**As a member or guest of Healthworks, I understand that Healthworks has the right to terminate my membership/guest pass if I violate the following code:**

Wear proper exercise attire, including athletic shoes and shirts at all times
Refrain from perfume/cologne use in the fitness center
Refrain from using profanity and offensive language
Refrain from behavior that disrupts another member's ability to enjoy the facility (i.e., using cell phones, dropping weights, excessive grunting, etc.)
Follow all staff instruction regarding the use of the equipment, machinery and facilities
Return all equipment used to its appropriate place
Refrain from cell phone usage while using the fitness center and equipment
Return used or soiled towels to linen receptacles
Wipe off exercise equipment after each use
Keep all liquids in a secured and covered container

___________ **(Initial)**

| **MEMBER SIGNATURE** | **DATE** |
|---|---|
| **STAFF SIGNATURE** | **DATE** |

# Waiver and Assumption of Risk

*Please consult with your physician before beginning any exercise program.*

I acknowledge that I have voluntarily chosen to participate in one or more physical exercise or fitness activity or sport programs (the "Programs"). I acknowledge (i) the nature of the risks of the particular Programs in which I have chosen to participate, and (ii) the strenuous nature of those Programs. I understand, for example, the risks associated with physical injury, abnormal blood pressure, heart attack and even death; as well as the risks associated with the negligence of a Tivity Health Services, LLC participating location and any other organization or individual participating or involved in providing or promoting any classes, functions, Programs, testing, or other activities that I participate in as a Tivity Health™ Program member (including without limitation the owners, officers, directors, employees, and representatives of any of the foregoing).

By signing this document, I expressly assume all risk for my health and well-being and expressly assume the other risks associated with participating in the Programs, including, but not limited to, the negligence of a Tivity Health participating location and any other organization or individual participating or involved in providing or promoting any classes, functions, Programs, testing, or other activities that I participate in as a Tivity Health Program member (including without limitation the owners, officers, directors, employees, and representatives of the foregoing). I also hereby release, waive, discharge and covenant not to sue any class instructor, any Tivity Health participating location, any sponsoring organization, Tivity Health, Inc., or any of their subsidiaries or any other organization or individual providing or promoting classes, functions, Programs, testing, or other activities that I participated in as a Tivity Health Program member (including without limitation the owners, officers, directors, employees, and representatives of any of the foregoing) at any time hereafter, from any and all demands, liabilities, losses, or damages (including death, bodily injury or damage to property) caused or alleged to be caused in whole or in part by the negligence of any of the foregoing people or entities. In addition, I agree that Tivity Health may engage in – and I hereby expressly consent to – (i) the recording (in video and/or still photo format) of my participation in Tivity Health classes, workshops or other programs, and (ii) the publication or other use by Tivity Health of any such recordings in social media, broadcast media, print media, general advertising and similar purposes.

I have read and understand this waiver and express assumption of risk. I have also read, understand, and will adhere to all guidelines and policies in regard to this benefit. This waiver and release shall survive the term of any agreement with a Tivity Health participating location or individual.

In the event that my physician has recommended any limitations to my physical activity or I have experienced any of the following conditions, I hereby attest that I have informed my physician of the condition(s) and have obtained express consent from my physician to participate in the Programs.

- Chest pains while at rest and/or during exertion, previous heart attack or high blood pressure
- Any heart or circulatory conditions, such as vascular disease, stroke, chest pain, congestive heart failure, poor circulation to the legs, valvular heart disease, blood clots
- Frequent fast, irregular heartbeats OR very slow heartbeats
- Diabetes
- Previous hip or spinal fracture (as an adult)
- Lung disease or shortness of breath after mild exertion, at rest, or in bed
- Open cuts on my feet that do not seem to heal
- An unexplained weight loss of ten (10) pounds or more in the past six (6) months
- More than two falls in the past year (no matter what the reason)
- More than one year since I have engaged in regular physical activity

| Print Member's Name | Member's Signature | Date |
|---|---|---|

| Emergency Contact Name | Contact Phone Number |
|---|---|

Confidential