



FITNESS CENTER MEMBERSHIP

Members who are inactive for more than 1 year are required to complete a new application and orientation. All rules and regulations established by BaylorWorx Rehabilitation & Fitness Center must be followed.

♥Name _____ Preferred Name _____

♥Address _____

♥City _____ State _____ Zip _____

♥Home Phone _____ Cell Phone _____

♥Work Phone _____ Ext. _____ Employer _____

♥Emergency Contact _____ Emergency Phone _____

♥Date of Birth _____ Gender: Male _____ Female _____

♥(If 17 yr old & Senior in High School, a parent/guardian must sign the Release of Liability & be present at your Fitness Center orientation)

♥E-Mail Address _____

♥How did you learn about BaylorWorx Rehabilitation and Fitness Center?
 ___ Newspaper _____ Friend
 ___ Health Fair _____ Radio
 ___ Internet _____ Physician
 ___ Other: _____

♥Health/Fitness History

1. Are you presently involved in a regular exercise program? _____ If yes, please list activity, duration, frequency, and intensity.

2. Do you or have you ever smoked? _____ Yes _____ No
 If you previously smoked, how long did you smoke, how often, and when did you quit? _____ If you currently smoke, how much? _____
3. Do you drink coffee or colas with caffeine? _____ Yes _____ No
 If yes, how much per day? _____
4. Are you pregnant? _____ Yes _____ No
5. How many meals do you usually eat per day? _____
6. Do you usually eat breakfast? _____ Yes _____ No

♥Medical History

Check any conditions or diseases you now have or have had in the past:

- | | |
|---|--|
| <input type="checkbox"/> heart attack, coronary bypass,
or other cardiac surgery | <input type="checkbox"/> unusual shortness of breath |
| <input type="checkbox"/> swollen, stiff, or painful joint | <input type="checkbox"/> limited range of motion in joints |
| <input type="checkbox"/> diabetes | <input type="checkbox"/> high blood pressure |
| <input type="checkbox"/> asthma | <input type="checkbox"/> arthritis |
| <input type="checkbox"/> chest discomfort | <input type="checkbox"/> stroke |

♥Fitness Goals

Please check specific goals:

- | | |
|--|---|
| <input type="checkbox"/> improve muscle tone and shape | <input type="checkbox"/> improve cardiovascular fitness |
| <input type="checkbox"/> improve diet/eating habits | <input type="checkbox"/> stop smoking/drinking |
| <input type="checkbox"/> improve strength | <input type="checkbox"/> improve flexibility |
| <input type="checkbox"/> lose weight/inches | <input type="checkbox"/> gain weight/muscle |
| <input type="checkbox"/> reduce stress | <input type="checkbox"/> increase energy |

Some additional fitness goals I would like to achieve are:

PAR-Q

♥PHYSICAL ACTIVITY READINESS QUESTIONNAIRE

For most people physical activity should not pose any problem or hazard. **PAR-Q** has been designed to identify the small number of adults for whom physical activity might be inappropriate, or for those who should have a more complete medical examination before undertaking physical exercise.

Common sense is your best guide in answering these few questions. Please read them carefully **and** circle the appropriate YES or NO opposite the question.

- YES NO 1.) Has the doctor ever said that you have a heart condition and that you should only do physical activity recommended by a doctor?
- YES NO 2.) Do you feel pain in your chest when you do physical activity?
- YES NO 3.) In the past month, have you had chest pain when you were not doing physical activity?
- YES NO 4.) Do you lose your balance because of dizziness or do you ever lose consciousness?
- YES NO 5.) Do you have a bone or joint problem that could be made worse by a change in your physical activity?
- YES NO 6.) Is your doctor currently prescribing drugs (for example, water pills) for your blood pressure or heart condition?
- YES NO 7.) Do you know of any other reason why you should not do physical activity?

If you answered "YES" to one or more of the above mentioned questions, you must obtain your Doctor's signature for consent as well as their phone number before the assessment can be conducted.

NAME _____ **DATE** _____

DR'S SIGNATURE _____ **PHONE #** _____

APPROVAL: The above mentioned has medical approval to participate in fitness programs and in the use of exercise equipment at various sites, including home or office, that may be provided by and/or recommended by BaylorWorx, a service of Baylor Medical Center at Waxahachie.

