



## Health Appraisal: Cardiac History

Please note that if you are a man over the age of 45, or a woman over the age of 55 with two or more of the following risk factors, we will require that a graded exercise test or diagnostic equivalent be done or have been done within the past 12 months. Alternatively, your physician can provide clearance for you to participate without further medical evaluation for these specific risk factors by signing below this section.

RISK FACTOR	DO YOU HAVE THIS OR ARE BEING TREATED FOR IT?	PLEASE EXPLAIN (ATTACH RECORDS OR PAGES IF NEEDED)
Heart Disease	yes/no	
High Blood Pressure	yes/no	
Diabetes	yes/no	
High Cholesterol	yes/no	
Smoking:	_____ packs per day for _____ of years, quit _____ (year).	
Family history of heart disease in parents, siblings under age 55?	yes/no	

PHYSICIAN SIGNATURE	DATE
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## Health Appraisal: Medical History

RISK FACTOR	DO YOU HAVE THIS OR ARE BEING TREATED FOR IT?	PLEASE EXPLAIN (ATTACH RECORDS OR PAGES IF NEEDED)
Chest pain at rest or with activity	yes/no	
Heart murmur	yes/no	
Dizziness or fainting	yes/no	
Heart rhythm irregularity	yes/no	
Unusual shortness of breath	yes/no	
Stroke	yes/no	
COPD/Emphysema	yes/no	
Cancer	yes/no	
Seizures	yes/no	
Arthritis	yes/no	
Joint problems	yes/no	
Back problems	yes/no	
Chronic pain	yes/no	
Cancer	yes/no	
Fractures	yes/no	
Pregnant	yes/no	
Alcohol use	yes/no	
Currently exercising	yes/no	
Other useful information:		

## Health Appraisal: Surgical and Hospitalization History

SURGERY / HOSPITALIZATION	DATE	PLEASE EXPLAIN (ATTACH RECORDS OR PAGES IF NEEDED)

## Personal Health and Fitness Goals


## Physician Clearance for Program Participation

Heart rate and blood pressure parameters are requested if graded exercise test results are not available for those individuals with a cardiac history.

WELLSTYLE MEMBERSHIP (INCLUSIVE OF UNSUPERVISED, SUPERVISED, GYM AND POOL PROGRAMS)	
I am giving my clearance for this individual to exercise in these types of programs with the following parameters (please write "none" if appropriate):	
Maximal allowable heart rate ____	Maximal allowable systolic/diastolic pressures ____ / ____
PHYSICIAN SIGNATURE	DATE

WELLSTYLE UNLIMITED WATER PROGRAM (SUPERVISED AQUATIC EXERCISE)	
I am giving my clearance for this individual to exercise in this type of program with the following parameters (please write "none" if appropriate):	
Maximal allowable heart rate ____	Maximal allowable systolic/diastolic pressures ____ / ____
PHYSICIAN SIGNATURE	DATE

WELLSTYLE INDEPENDENT WATER PROGRAM (UNSUPERVISED AQUATIC EXERCISE)	
I am giving my clearance for this individual to exercise in this type of program with the following parameters (please write "none" if appropriate):	
Maximal allowable heart rate ____	Maximal allowable systolic/diastolic pressures ____ / ____
PHYSICIAN SIGNATURE	DATE

## Acknowledgements

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Please read and INITIAL the following indicating your agreement:

\_\_\_\_\_ I understand that I am required to check in at the front desk each time I visit the CRFC.

\_\_\_\_\_ Members who join for the full membership have three months to take advantage of the fitness evaluation which is included in the initial membership.

\_\_\_\_\_ It is my responsibility to notify the front desk at 922-1139 to cancel or reschedule any appointment.

\_\_\_\_\_ A membership freeze is allowed for a \$10.00 fee. A freeze may last up to three months.

\_\_\_\_\_ Annual memberships paid in full are non-refundable.

\_\_\_\_\_ I understand that I will not be sent a bill for my membership and that monthly payments are due on or before the first of the month. Initiation fees are non-refundable, and a thirty-(30) day advance written notice is required to cancel any monthly membership.

\_\_\_\_\_ I understand that I will be required to obtain a physician clearance before participation in program.

\_\_\_\_\_ I understand and agree that Baylor All Saints Medical Center will not have or assume any financial responsibility or liability for the expense of medical treatment or compensation for any injury I may sustain during or resulting from participating in this program.

\_\_\_\_\_ I understand that I am responsible for my own actions, and there is a possibility that I may be unsupervised by CRFC staff during off-peak times.

\_\_\_\_\_ I acknowledge that the CRFC shall not be responsible or liable to members or their guests for loss or damage to articles/property lost or stolen at the center, including their automobiles and the contents there of. CRFC will provide Lockers and Two Towels per-person.

\_\_\_\_\_ In consideration of the benefits and other activities of the Carter Rehab and Fitness Center, I apply for membership to begin on: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Applicant agrees to the above and acknowledges that this is a binding agreement by signing below:

Signature of Applicant

Date

Signature of CRFC Witness

Date

For Office Only:

Payment method	Cash _____	Credit Card _____	Check# _____	Other _____
Amount collected	\$ _____	Collected by:		
Membership type	WCOM WEMP	WCOR WSMAT	Land Aerobic Water Aerobic	Full-time Student Open Pool EDI