HEALTH FIT
POWERED BY SARASOTA MEMORIAL

New Member Appointments Instructions

1. Your HEALTH RISK ASSESSMENT (HRA) is scheduled for:
   _____/_____/_____ at _____:_____AM / PM with ____________________________.

At this time, please have **COMPLETED PAPERWORK** ready for your appointment. Please come **with close-toed shoes**. This appointment will last approximately **30-60 minutes**. We will begin this appointment with a one-on-one consultation to discuss your current fitness level, health considerations, and specific goals. Other topics reviewed and assessments completed during this appointment include:

- Introduction of Personal Trainer or Exercise Specialist
- Identify past and present health conditions
- Identify current fitness levels + goals
- Assess blood pressure, height, and body composition
- Review Group Exercise Program options

If no medical clearance is needed as identified by the Pre-Participation Screening, then the following assessments may be done.

- 5-minute treadmill aerobic fitness test
- Sit and reach flexibility assessment
- Other physical assessments (as needed)

2. Your second appointment is the **EXERCISE & PROGRAM ORIENTATION (EPO)** and will be scheduled at the completion of the HRA appointment providing medical clearance is not needed.

Note: All HealthFit members may use gym equipment and facilities upon joining. Members are provided exercise recommendations and orientations by HealthFit staff after medical clearance is received when appropriate. Members do not need to wait for medical clearance to use HealthFit facilities.

Please come **dressed to exercise**. We will go over beginning exercise recommendations at this time. The exercise specialist will determine the appropriate machine settings, and explain how to keep your exercise program safe and effective. This appointment will last approximately **60 minutes**. Other topics reviewed and assessments completed during this appointment include:

- FitLinxx ID # and main kiosk operation
- FitLinxx cardiovascular sign in/out procedures
- Identify Cardiac Rehab facilities and usage
- Towel service and fitness machine cleaning
- Heart rate recommendations for exercise
- Review television audio
- Treadmill instruction and heart rate sensor information (when appropriate)
- FitLinxx fitness machine setup (when appropriate)
- Print out of your starter FitLinxx program

PLEASE NOTE:

We ask that you arrive on time to your scheduled appointment. If you are <u>more than 15 minutes late</u>, we may need to cancel your appointment. Please call **917-7000** at least 24 hours in advance to reschedule or cancel your appointment. **<u>HRA and EPO cancellations less than 24 hours notice or no shows will incur a $10 cancellation fee.</u>**

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COMPLETE FRONT + BACK

Membership Information

Name ______________________________________ Street Address __________________________________

City _________________State ______ Zip __________ ____

Date of Birth _____/_____/_______ Age ____________ Gender ☐ MALE ☐ FEMALE

Primary Phone ________________________________ Other Phone ________________________________

Email ______________________________________ Occupation: __________________________________

Please select a 5 digit FitLinxx ID #: 1st Choice: _ _ _ _ _ 2nd Choice: _ _ _ _ _

Your shirt size: XS S M L XL XXL XXXL Exercise Specialist Name: ____________________

Pre-participation Screening

Please put a checkmark in the box if the statement applies to you.

Heart History

You have had:

- ☐ Heart attack
- ☐ Heart surgery
- ☐ Cardiac catheterization
- ☐ Heart Valve Disease
- ☐ Coronary angioplasty (PTCA)
- ☐ Pacemaker or implantable cardiac defibrillator
- ☐ Stroke
- ☐ Rhythm disturbance
- ☐ Heart failure
- ☐ Heart transplant
- ☐ Congenital heart disease

Other Health Issues

- ☐ You experience chest discomfort with exertion.
- ☐ You experience unreasonable breathlessness.
- ☐ You experience dizziness, fainting, or blackouts.
- ☐ You take heart medications.
- ☐ You have diabetes.
- ☐ You have lung disease.
- ☐ You have burning or cramping sensation in your lower legs when walking short distances.
- ☐ You have musculoskeletal problems that limit your physical activity.
- ☐ You are pregnant.

If you check marked ONE OR MORE of these statements, you must have your physician fill out our medical clearance form, PRIOR to beginning exercise or your health and fitness assessment at Healthplex Fitness Center.

Cardiovascular Risk Factors

- ☐ You are a man age 45 years or older.
- ☐ You are a woman age 55 years or older, had a hysterectomy, or are postmenopausal.
- ☐ You smoke, or quit smoking within the previous 6 months.
- ☐ Your blood pressure at rest has been over 140/90 on multiple occasions.
- ☐ You take blood pressure medication.
- ☐ Your blood cholesterol level is over 200 mg/dL.
- ☐ You have a father or brother who had a heart attack or heart surgery before age 55.
- ☐ You have a mother or sister who had a heart attack or heart surgery before age 65.
- ☐ You are physically inactive (i.e., less than 30 minutes of exercise on at least 3 days per week).
- ☐ Your body mass index (BMI) score is 30 kg/m^2 or more.

If you check marked TWO OR MORE of these statements, you must have your physician fill out our medical clearance form, PRIOR to beginning exercise or your health and fitness assessment at Healthplex Fitness Center.

Please note: If your health changes so that you have to check mark any of the above statements, you must immediately tell HealthFit in writing of the changes.

By signing below, I am certifying that I have read, understood and completed this questionnaire, and all other information contained in this application. All information is true to my full satisfaction.

______________________________________ ____________

PARTICIPANT'S SIGNATURE **DATE**

Source: American College of Sports Medicine/American Heart Association Joint Position Statement: Recommendations for cardiovascular screening, staffing, and emergency policies at health/fitness facilities. Medicine and Science in Sports and Exercise, 1998:1018.

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Lifestyle Questionnaire

This information helps Healthplex Fitness Center staff to safely design an appropriate exercise program for you. All information is kept confidential.

<u>Past and/or Present Health Conditions</u>: (Check all that apply)

Cardiovascular	**Musculoskeletal**	**Other**
❑ Chest Discomfort	❑ Osteoporosis	❑ Anemia
❑ Coronary Bypass	❑ Osteopenia	❑ Depression
❑ Current Heart Murmur	❑ Shoulder Problems	❑ Diabetes
❑ Skipped or Rapid Heart Beat	❑ Swollen, Sore, Painful Joints	❑ Epilepsy or Seizures
❑ Heart Attack	❑ Hernia	❑ Hearing Impairment
❑ High Blood Pressure	❑ Rheumatoid Arthritis	❑ Parkinson's Disease
❑ High Cholesterol	❑ Limited ROM on Joints	❑ Post-Natal
❑ Low Blood Pressure	❑ Parent with hip fracture	❑ Pregnant
❑ Peripheral Vascular Disease	❑ Other	❑ Pre-Pregnancy
❑ Phlebitis or Emboli		❑ Previous Heat Stroke
❑ Rheumatic Fever		❑ Smoking
❑ Stroke or Brain Injury		❑ Thyroid Problems
□ Stent (coronary)	**Pulmonary**	❑ Vision Impairment/Cataracts
Musculoskeletal	❑ Allergies	❑ Kidney or Liver Disease
❑ Ankle Swelling	❑ Asthma	❑ Cancer
❑ Back Problems	❑ Asthma (exercise induced)	❑ Muscular Dystrophy
❑ Broken Bones - fracture	❑ Bronchitis	❑ Multiple Sclerosis
❑ Fibromyalgia	❑ Chronic Recurring Cough	❑ Alzheimer's Disease
❑ Foot Problems	❑ Emphysema	❑ Mental Illness
❑ Joint Replacement	❑ Pneumonia	❑ Glucocorticoids
❑ Knee Problems	❑ Pulmonary Edema	
❑ Use of assisted mobility devices (walker, cane, wheelchair, or other device)		

Notes and Contraindications:

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Please list all **medications** you are currently taking, and the reason for the medication:

Medication	Reason		Medication	Reason

Any other medical problems/concerns not already identified? No _____Yes _____ (please list below)

Primary Emergency Contact Name_______________________ Phone_________________Relation_____________
Secondary Emergency Contact Name_________________________Phone________________Relation_____________
Primary Care Physician Name_____________________________Phone ________________________________
Secondary Care Physician Name_____________________________Phone ________________________________

Activities you participated in the past or currently.

❑ Aerobics	❑ Racquetball	❑ Volleyball
❑ Aqua Aerobics	❑ Hiking	❑ Running
❑ Walking	❑ Horseback riding	❑ Sailing
❑ Badminton	❑ Ice Skating	❑ Scuba Diving
❑ Basketball	❑ Kayaking	❑ Skipping rope
❑ Biking	❑ Kickboxing	❑ Soccer
❑ Bowling	❑ Line Dancing	❑ Softball
❑ Canoeing	❑ Martial Arts	□ Square Dancing
❑ Dance	❑ Mountain Biking	❑ Squash
❑ Golf	❑ Pickle ball	❑ Swimming
❑ Rowing	❑ Walking	❑ Tai Chi
❑ Tennis	❑ Triathlon	❑ Others:

Fitness classes you have done or would like to do: (Check all that apply)

❑ Aerobics	❑ Cardio Sculpt	❑ Rowing
❑ Basic Training	❑ Cardio Dance	❑ Spinning/Studio Cycling
❑ Body Conditioning	❑ Hi/Low Impact	❑ Step, Jump & Pump
❑ Body Max	❑ Kickboxing/Box Aerobics	❑ Stretch
❑ Jazzercise	❑ Mommy and Me	❑ Water Aerobics
❑ Body Sculpting	❑ Physioball	❑ Yoga/Power Yoga
❑ Boot Camp	❑ Pilates	❑ Tai Chi

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Fitness Goals: (Check all that apply)

☐ Exercise Regularly	☐ Improve Strength	☐ Improve Balance
☐ Lose Weight	☐ Injury Rehab	☐ Improve Flexibility
☐ Cardiovascular Fitness	☐ Sports Conditioning	☐ Other:
☐ Muscle Tone/Shape	☐ Endurance/Energy	

Have you worked with a personal trainer? **Yes** **No**
Have you exercised in a fitness/wellness center previously? **Yes** **No**
Your fitness level today: (1 = worst, 10 = best) **1** 2 3 4 **5** 6 7 8 9 **10**
If currently working out, are you getting the results you desire? **Yes** **No**
Describe your history with exercise. (free weights, machines, treadmill, bikes, classes, etc.)

____

____

Nutrition:
How many calories do you eat daily? _________________
Do you know your resting metabolic rate? Yes No If Yes: __________

Other:
How long is you commute to HealthFit? <5min. 5-10min 15-20min 20-25min >25min
How many weekly workouts will you do? ________________________
How long are your typical workouts? <30min. 30min. 60min. 90min. However long it takes
How can the staff at HealthFit assist you in attaining your fitness goals?

____

____

Your commitment to exercise is: 1= not very 5=moderate 10 = whatever it takes

1 2 3 4 **5** 6 7 8 9 **10**

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To be completed by Exercise Specialist/Personal Trainer

Date: _________ Body Weight: __________ Height: _____________

BMI: _________ Blood Pressure: __________ Resting Heart Rate: _________

Notes: