

Welcome to Personal Training at Galter LifeCenter!

Together, you and your trainer will develop a balanced exercise program to address your specific needs, goals and lifestyle.

Your experience will include:

Evaluation

- Review of health history questionnaires
- Fitness Assessment
 - Cardiovascular Endurance
 - Muscular Strength
 - Muscular Endurance
 - Flexibility
 - Body Composition
 - Balance, Posture, Alignment
- Intake of recommendations from health care providers (Physician, Nurse Practitioner, Physical Therapist, Dietitian, Massage Therapist, Chiropractor, etc.)

These baseline measurements will be gathered during your first session.

- Goal-Setting
 - After assessing your health and fitness status, your trainer will guide you in setting clear, measurable and realistic goals.

Program Design

- Based on your evaluation results and goals, the trainer will create a comprehensive program to address your goals. Get ready for a smart workout, support, motivation and FUN!

Re-evaluation

- Your trainer will periodically repeat the fitness assessments in order to measure change and monitor progress toward your goals.

Please read and complete the attached forms and bring them to your first appointment. Come dressed for exercise, as your fitness evaluation will take place during that session. Feel free to contact Amy Beck, Personal Training Manager, 773-878-9936, ext. 7318 or ABeck@SwedishCovenant.org, at any time with questions or comments. Experience the Science of Feeling Better at Chicago's Leading Medical Fitness Center!

Personal Training Guidelines

1. All clients must complete the proper paperwork, including guidelines, health history, exercise history and liability waiver prior to beginning a personal training program. For your safety a physician's release for exercise may be necessary before participation is approved.
2. All personal training sessions must be purchased in advance.
3. The client is responsible for checking in at the Courtesy Desk prior to each session to redeem ("burn") a session from the prepaid package. Please allow time to do this before the scheduled appointment.
4. 24 hours' notice is required to change or cancel personal training appointments. If 24 hours' notice is not given, the session will be forfeited. Please notify your trainer directly in the case that you need to change or cancel an appointment.
5. If a personal trainer cancels an appointment with less than 24 hours notice, the trainer will provide one session at no charge.
6. All personal training sessions will expire six months from the date of purchase. Extensions must be approved by the manager.
7. In the case of a trainer's illness or vacation, the client may request a substitute trainer.
8. Our goal is to provide you with excellent service! Please contact us any time; we welcome any questions and feedback.

Please sign below to indicate that you have read and understood these guidelines.

Thank you!

Amy Beck
Personal Training Manager
773-878-9936, ext. 7318
ABeck@SwedishCovenant.org

CLIENT'S SIGNATURE

DATE (MM/DD/YY)

Clients, please retain a copy for your records.

Health History and Physical Activity Readiness Questionnaire

Client Information

NAME		SEX <input type="checkbox"/> M <input type="checkbox"/> F	BIRTHDATE (MM/DD/YY) / /	
ADDRESS		CITY	STATE	ZIP
HOME PHONE	WORK OR CELL PHONE		EMAIL ADDRESS	
PHYSICIAN NAME			OFFICE PHONE	
PHYSICIAN ADDRESS		CITY	STATE	ZIP
EMERGENCY CONTACT		RELATIONSHIP	PHONE	

Exercise Survey

OCCUPATION		WORK DAY ACTIVITY LEVEL <input type="checkbox"/> Sedentary <input type="checkbox"/> Active
Current exercise program <input type="checkbox"/> Yes <input type="checkbox"/> No	Describe	
Frequent sports activities <input type="checkbox"/> Yes <input type="checkbox"/> No	Describe	
Do you take your pulse during exercise <input type="checkbox"/> Yes <input type="checkbox"/> No	How high does it go up?	
What is your main reason for joining Galter LifeCenter?		
What are your main exercise goals?		

Goals

Please circle the exercise goals that are important to you

Improve cardiovascular fitness

Improve moods and stress

Feel Better

Body-fat or weight loss

Improve flexibility

Enjoyment

Reshape or tone my body

Increase strength

Other

Improve sport performance

Increase energy level

General Health Condition

Does your physician know you are participating in this exercise program?

Yes No

Do you have any pre-existing physical or medical condition that could be aggravated by exercise?

Yes No

Obesity (more than 20% over ideal weight)

Yes No

List your current medications (prescription and over-the-counter):

Lifestyle and Health History Questionnaire

This questionnaire serves as a part of a pre-screening tool for both exercise testing and exercise participation. If you respond yes to any of the questions, medical clearance may be necessary before participating in exercise testing or an exercise program is allowed.

Health History

1. How would you describe your present state of health?

very well healthy unhealthy ill other: _____

2. When was the last time you visited your physician? _____

3. Have you ever had your cholesterol checked? Yes No

Date of test: _____ What were the results?

Total Cholesterol: _____ HDL: _____ LDL: _____ TG: _____

4. Have you ever had your blood sugar checked? Yes No What were the results? _____

Please check the appropriate boxes below and explain any items marked YES.

5. Past History		If yes, please explain
Allergies	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Amenorrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Anxiety	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Celiac disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Chronic sinus condition	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Constipation	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Crohn's disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Depression	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Diarrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Disease of the arteries, stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Eating disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Epilepsy mellitus	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Gastroesophageal reflux disease (GERD)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Heart attack	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Heart murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No	
High blood pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Hypoglycemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Hypo/hyperthyroidism	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Insomnia	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Intestinal problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Irritability	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Irritable bowel syndrome (IBS)	<input type="checkbox"/> Yes <input type="checkbox"/> No	

5. Past History (continued)		If yes, please explain
Lung disease / problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Major surgeries	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Menopausal symptoms	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Pregnant	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Premenstrual syndrome (PMS)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Polycystic ovary syndrome (POSC)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Osteoporosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Skin problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Ulcer	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Past injuries (back, knees, ankles, other)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Describe any other health conditions that you may have had		
6. Family History (immediate family)		
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Congenital heart disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Heart attacks	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Heart operations	<input type="checkbox"/> Yes <input type="checkbox"/> No	
High blood pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	
High cholesterol	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Osteoporosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Other major illness	<input type="checkbox"/> Yes <input type="checkbox"/> No	
7. Present Symptoms		
Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Awake short of breath	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Back pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Chest pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Cough or exertion	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Coughing up blood	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Heart palpitations	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Shortness of breath	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Swollen legs	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Use more than one pillow for sleep	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Other	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Diet and Eating Habits

8. What are your dietary goals? _____
9. Have you ever followed a modified diet? Yes No
If so, describe: _____
10. Are you currently following a specialized diet (e.g., low-sodium or low fat)? Yes No
If so, describe: _____
11. Why did you choose this diet? _____
Was the diet prescribed by a physician? Yes No
How long have you been on the diet? _____
12. Have you ever met with a registered dietitian? Yes No
Are you interested in meeting with one? Yes No
13. What do you consider to be the major issues in your diet and eating plan? (e.g., eating late at night, snacking on high-fat foods, skipping meals or lack of variety) _____
14. How many 8-ounce glasses of water do you drink per day? _____
15. Do you have any food allergies or intolerance? Yes No Describe: _____
16. Who prepares your food? Self Spouse Parent Minimal preparation
17. How many times per week do you dine out? _____
18. Please specify the type of restaurants you dine at for each meal:
Breakfast: _____ Lunch: _____
Dinner: _____ Snacks: _____
19. Do you crave any foods? Yes No Specify: _____
20. How is your appetite affected by stress? Increased Not affected Decreased
21. Do you drink alcohol? Yes No How many drinks per week? _____
22. Do you drink caffeinated beverages? Yes No Average number per day: _____
23. Do you use tobacco? Yes No How much (cigarettes, cigars, chewing tobacco) per day? _____
24. Do you take any vitamin, mineral or herbal supplements? Yes No
Please list type and amount per day: _____

Sports and Physical Activity

25. Do you currently participate in any structured physical activity? Yes No
If so, please describe: _____ minutes of cardiovascular activity, _____ times per week
_____ strength-training sessions per week
_____ minutes of flexibility training, _____ times per week
_____ minutes of sports per week
List sports: _____
Do you engage in any form of regular physical activity: Yes No Describe: _____
Please describe your activity level during the work day: _____
26. Have you experienced any injuries that may limit your physical activity?
If so, please describe: _____
27. On a scale of 1-10, how ready are you to adopt a healthier lifestyle: 1 = very unlikely to 10 = very likely _____

43. Would an exercise program benefit your job? Yes No

44. What types of exercise interest you?

- Walking Stationary biking Jogging Rowing
 Swimming Racquetball Dance exercise Cycling
 Tennis Strength training Stretching
 Other aerobic activities _____

Readiness to Change Questionnaire

	YES	NO
1. Are you looking to change a specific behavior?	<input type="checkbox"/>	<input type="checkbox"/>
2. Are you willing to make this behavioral change a top priority?	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you tried to change this behavior before?	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you believe there are inherent risks/dangers associated with not making this behavioral change?	<input type="checkbox"/>	<input type="checkbox"/>
5. Are you committed to making this change even though it may prove challenging?	<input type="checkbox"/>	<input type="checkbox"/>
6. Do you have the support for making this change from friends, family and loved ones?	<input type="checkbox"/>	<input type="checkbox"/>
7. Besides health reasons, do you have other reasons for wanting to change this behavior?	<input type="checkbox"/>	<input type="checkbox"/>
8. Are you prepared to be patient with yourself if you encounter obstacles, barriers, and/or setbacks?	<input type="checkbox"/>	<input type="checkbox"/>

I have answered the above questions to the best of my knowledge.

SIGNATURE

PRINT NAME

DATE (MM/DD/YY)

Weight-Loss Readiness Quiz

Are you ready to lose weight? Your attitude about weight loss affects your ability to succeed. Take this Weight-loss Readiness Quiz to learn if you need to make any adjustments before you begin. Mark each item T (true) or F (false). Please be honest! It's important that these answers reflect the way you really are, not how you would like to be. A method for interpreting your readiness for weight loss follows:

	T	F
1. I have thought a lot about my eating habits and physical activities to pinpoint what I need to change.	<input type="checkbox"/>	<input type="checkbox"/>
2. I have accepted the idea that I need to make permanent, not temporary, changes in my eating and activities to be successful.	<input type="checkbox"/>	<input type="checkbox"/>
3. I will only feel successful if I lose a lot of weight.	<input type="checkbox"/>	<input type="checkbox"/>
4. I accept the idea that it's best if I lose weight slowly.	<input type="checkbox"/>	<input type="checkbox"/>
5. I'm thinking of losing weight now because I really want to, not because someone else thinks I should.	<input type="checkbox"/>	<input type="checkbox"/>
6. I think losing weight will solve other problems in my life.	<input type="checkbox"/>	<input type="checkbox"/>
7. I am willing and able to increase my regular physical activity.	<input type="checkbox"/>	<input type="checkbox"/>
8. I can lose weight successfully if I have no "slip-ups."	<input type="checkbox"/>	<input type="checkbox"/>
9. I am ready to commit some time and effort each week to organizing and planning my food and activity programs.	<input type="checkbox"/>	<input type="checkbox"/>
10. Once I lose some initial weight, I usually lose the motivation to keep going until I reach my goal.	<input type="checkbox"/>	<input type="checkbox"/>
11. I want to start a weight-loss program, even though my life is unusually stressful right now.	<input type="checkbox"/>	<input type="checkbox"/>

Scoring the Weight-Loss Readiness Quiz

To score the quiz, look at your answers next to items 1, 2, 4, 5, 7, and 9. Score "1" if you answered "true" and "0" if you answered "false."

For items 3, 6, 8, 10 and 11, score "0" for each true answer and "1" for each false answer.

To get your total score, add the scores of all questions.

No one score indicates for sure whether you are ready to start losing weight. However, the higher your total score, the more characteristics you have that contribute to success. As a rough guide, consider the following recommendations:

- If you scored 8 or higher, you probably have good reasons for wanting to lose weight now and a good understanding of the steps needed to succeed. Still, you might want to learn more about the areas where you scored a "0" (see "Interpretation of Quiz Items").
- If you scored 5 to 7, you may need to reevaluate your reasons for losing weight and the methods you would use to do so. To get a start, read the advice given on the next page for those quiz items where you received a score of "0."
- If you scored 4 or less, now may not be the right time for you to lose weight. While you might be successful in losing weight initially, your answers suggest that you are unlikely to sustain sufficient effort to lose all the weight you want, or keep off the weight that you do lose. You need to reconsider your weight-loss motivations and methods and perhaps learn more about the pros and cons of different approaches to reducing. To do so, read the advice on the next page for those quiz items where you scored "0."

YOUR SCORE		
Q#	T	F
1	___	___
2	___	___
4	___	___
5	___	___
7	___	___
9	___	___
3	___	___
6	___	___
8	___	___
10	___	___
11	___	___
TOT	___	___
TOTAL ALL		___

Interpretation of Quiz Items

Your answers to the quiz can clue you in to potential stumbling blocks to your weight-loss success.

Any item score of “0” indicates a misconception about weight loss, or a potential problem area. While no individual item score of “0” is important enough to scuttle your weight-loss plans, you should consider the meaning of those items so that you can best prepare yourself for the challenges ahead. The numbers below correspond to the question numbers.

1. It has been said that you can't change what you don't understand. You might benefit from keeping records for a week to help pinpoint when, what, why, and how much you eat. This tool also is useful in identifying obstacles to regular physical activity.
2. Making drastic or highly restrictive changes in your eating habits may allow you to lose weight in the short-run, but be too hard to live with permanently. Similarly, your program of regular physical activity should be one you can sustain. Both your food plan and activity program should be healthful and enjoyable.
3. Most people have fantasies of reaching a weight considerably lower than they can realistically maintain. Rethink your meaning of “success.” A successful, realistic weight loss is one that can be comfortably maintained through sensible eating and regular activity. Take your body type into consideration. Then set smaller, achievable goals. Your first goal may be to lose a small amount of weight while you learn eating habits and activity patterns to help you maintain it.
4. If you equate success with fast weight loss, you will have problems maintaining your weight. This “quick fix” attitude can backfire when you face the challenges of weight maintenance. It's best—and healthiest—to lose weight slowly, while learning the strategies that allow you to keep the weight off permanently.
5. The desire for, and commitment to, weight loss must come from you. People who lose and maintain weight successfully take responsibility for their own desires and decide the best way to achieve them. Once this step is taken, friends and family are an important source of support, not motivation.
6. While being overweight may contribute to a number of social problems, it is rarely the single cause. Anticipating that all of your problems will be solved through weight loss is unrealistic and may set you up for disappointment. Instead, realize that successful weight loss will make you feel more self-confident and empowered, and that the skills you develop to deal with your weight can be applied to other areas of your life.
7. Studies have shown that people who develop the habit of regular, moderate physical activity are most successful at maintaining their weight. Exercise does not have to be strenuous to be effective for weight control. Any moderate physical activity that you enjoy and will do regularly counts. Just get moving!
8. While most people don't expect perfection of themselves in everyday life, many feel that they must stick to a weight-loss program perfectly. This is unrealistic. Rather than expecting lapses and viewing them as catastrophes, recognize them as valuable opportunities to identify problem triggers and develop strategies for the future.
9. Successful weight loss is not possible without taking the time to think about yourself, assess your problem areas, and develop strategies to deal with them. Success takes time. You must commit to planning and organizing your weight loss.
10. Do not ignore your concerns about “going the distance,” because they may indicate a potential problem. Think about past efforts and why they failed. Pinpoint any reasons, and work on developing motivational strategies to get you over those hurdles. Take your effort one day at a time; a plateau of weight maintenance within an ongoing weight-loss program is perfectly okay.
11. Weight loss itself is a source of stress, so if you are already under stress, it may be difficult to successfully implement a weight-loss program at this time. Try to resolve other stressors in your life before you begin a weight-loss effort.

GENERAL RELEASE and ASSUMPTION OF RISK

In consideration of my using the Facilities and Equipment (both as hereinafter defined) located at Galter LifeCenter and of my participating in the Personal Training Program offered by LifeCenter on the Green, Inc., d/b/a Galter LifeCenter (hereinafter referred to as the "Program"), I HEREBY RELEASE, WAIVE AND FOREVER DISCHARGE LIFECENTER ON THE GREEN, INC., SWEDISH COVENANT HOSPITAL, THEIR AFFILIATES, THEIR DIRECTORS OR TRUSTEES, OFFICERS, EMPLOYEES, PERSONNEL, VOLUNTEERS, AND ANY OF THEIR INSTRUCTORS, AGENTS OR REPRESENTATIVES ("RELEASEES"), FROM ALL LIABILITY TO ME, MY SPOUSE, LEGAL REPRESENTATIVES, HEIRS AND ASSIGNS AND ANY PERSON CLAIMING THROUGH OR UNDER MYSELF OF AND FROM ANY AND ALL PRESENT AND FUTURE CLAIMS, DEMANDS, DAMAGES, ACTIONS, OR RIGHTS OF ACTION, WHETHER LEGAL OR IN EQUITY, ARISING FROM OR BY REASON OF ANY BODILY INJURY OR PERSONAL INJURIES KNOWN OR UNKNOWN, DEATH, LOSS OR THEFT OF PERSONAL PROPERTY OR PROPERTY DAMAGE THAT MAY OCCUR AS A RESULT OF MY PARTICIPATION IN THE PROGRAM, WHETHER RESULTING FROM THE NEGLIGENCE OF THE RELEASEES OR NOT.

Initial _____

I FURTHER HEREBY RELEASE, WAIVE AND FOREVER DISCHARGE RELEASEES FROM ALL LIABILITY TO ME, MY SPOUSE, LEGAL REPRESENTATIVES, HEIRS AND ASSIGNS AND ANY PERSON CLAIMING THROUGH OR UNDER MYSELF OF AND FROM ANY AND ALL PRESENT AND FUTURE CLAIMS, DEMANDS, DAMAGES, ACTIONS, OR RIGHTS OF ACTION, WHETHER LEGAL OR IN EQUITY, ARISING FROM OR BY REASON OF ANY BODILY INJURY OR PERSONAL INJURIES KNOWN OR UNKNOWN, DEATH, LOSS OR THEFT OF PERSONAL PROPERTY OR PROPERTY DAMAGE THAT MAY OCCUR IN, ON OR ABOUT THE GALTER LIFECENTER'S PREMISES OR AS A RESULT OF MY USING OR MISUSING THE FACILITIES, INCLUDING, BUT NOT LIMITED TO, THE NURSERY, AEROBIC STUDIO, POOL AREA AND RUNNING TRACK (THE "FACILITIES"), AND THE EQUIPMENT, INCLUDING, BUT NOT LIMITED TO, THE CARDIOVASCULAR AND EXERCISE WEIGHT EQUIPMENT, TREADMILLS, STATIONARY BICYCLES AND STAIR MACHINES (THE "EQUIPMENT"), AND/OR AS A RESULT OF MY PARTICIPATION IN THE PROGRAM, WHETHER RESULTING FROM THE NEGLIGENCE OF THE RELEASEES OR Not.

Initial _____

I understand and am aware that the physical exercise required by the Program, including the use of Equipment, is a potentially hazardous activity. 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 the Equipment with knowledge of the dangers involved. I HEREBY AGREE TO EXPRESSLY ASSUME AND ACCEPT ANY AND ALL RISKS OF INJURY, DAMAGES OR DEATH THAT MAY OCCUR TO ME IN, ON OR ABOUT THE GALTER LIFECENTER'S PREMISES, FACILITIES OR EQUIPMENT OR AS A RESULT OF MY PARTICIPATION IN THE PROGRAM.

Initial _____

I do hereby further declare myself to be physically sound and suffering from no condition, impairment, disease, infirmity, or other illness that would prevent my participation or use of the Equipment in connection with the Program except as hereinafter stated.

Initial _____

I further release the Releasees from any claim whatsoever on account of first aid treatment, emergency medical services or other services rendered to me during my participation in the Program.

Initial _____

I agree to indemnify and hold harmless the Releasees from and against all claims, demands, lawsuits, liabilities and costs (including reasonable attorneys' fees and court costs) brought or commenced by any person or entity for the recovery of damages for the injury, illness and/or death of any person or damage to property arising out of my negligent acts or omissions.

I expressly agree that this release and waiver agreement is intended to be as broad and inclusive as permitted by the law of the State of Illinois, and that if any portion thereof is held invalid, it is agreed that the balance shall, notwithstanding, continue in full legal force and effect.

I have read this agreement and fully understand that by signing this agreement, I am giving up legal rights and/or remedies which may be available to me.

Witness

Witness

Signature

Print Name of Witness

Print Name of Witness

Print Name

Date



A PART OF SWEDISH COVENANT HEALTH
 5157 N. Francisco Ave., Chicago, IL 60625
 773-878-9936 | 773-907-7486 (fax) | GalterLifeCenter.org

For office use only	Member # _____
Risk Stratification: <input type="checkbox"/> Low <input type="checkbox"/> Moderate <input type="checkbox"/> High	
<input type="checkbox"/> Fitness Consultation Date/Time _____	
Is a doctor's note recommended? <input type="checkbox"/> Yes <input type="checkbox"/> No Staff Initials _____	

HEALTH STATUS PRE-PARTICIPATION QUESTIONNAIRE

NAME _____

Do you currently have a primary care physician? Yes No If yes, physician's name _____

Phone Number _____ Hospital Affiliation _____

Mark all statements that apply to your current health condition to assess your health status.

History *Have you had:*

- a heart attack
- heart surgery
- cardiac catheterization
- coronary angioplasty (PTCA)
- pacemaker/implantable cardiac defibrillator/rhythm disturbance
- heart valve disease
- heart failure
- heart transplantation
- congenital heart disease

Symptoms *Do you:*

- experience chest discomfort with exertion
- experience unreasonable breathlessness
- experience dizziness, fainting, or blackouts
- experience ankle swelling
- experience unpleasant awareness of a forceful or rapid heart rate
- take heart medications

Other Health Issues *You:*

- have diabetes
- have asthma or other lung disease
- have a burning or cramping sensation in your lower legs when walking short distance
- have musculoskeletal problems that limit your physical activity
- have concerns about the safety of exercise
- take prescription medications
- are pregnant
- other: _____

If you marked any of these statements in the above three sections, **you are considered high risk and Galter LifeCenter highly recommends** that you consult your physician and obtain medical clearance prior to engaging in physical activity.

Cardiovascular Risk Factors

- Age (Men \geq 45/ Women \geq 55)
- Family history (first degree relative, which includes biological father and mother and full, biological brothers and sisters, who have had heart attack(s) or heart surgery (male before 55, female before 65).
- Current smoker or have quit within the last six months
- Physically inactive (< 30 minutes of physical activity at least three days per week)
- Body Mass Index \geq 30
- Hypertension (blood pressure > 140/90 mm Hg)
 - I take blood pressure medication
 - blood pressure unknown
- Hypercholesterolemia (total cholesterol > 200 mg/dL)
 - cholesterol level unknown
- Prediabetes (fasting blood sugar >100)
 - prediabetes unknown

If you marked two or more of these statements **you are considered moderate risk and Galter LifeCenter highly recommends** that you participate in a fitness consultation/assessment and/or consult with your physician or other appropriate health care provider before engaging in physical activity.

None of the above history, symptoms or risk factors

You should be able to exercise safely without consulting your physician or other appropriate health care provider in a self-guided program. However, Galter LifeCenter strongly recommends participating in a fitness consultation/assessment and orientation in order to provide you with the best service and care.

Comments: _____

I have answered the above questions to the best of my knowledge and

___ I will obtain medical clearance prior to beginning my membership

___ I will decline medical clearance prior to beginning my membership and know that I assume responsibility for any such consequences.

SIGNATURE _____

DATE _____