St. Joseph's/Candler
www.sjchs.org

Wellness Center

Information Sheet & Policies and Procedures

First Name: _____

Last Name: _____

Date of Birth: _____ Age: _____

☐ Male ☐ Female

FOR OFFICE USE ONLY
Account # _____

Social Security #: _____

Address: _____

City / State: _____

Zip Code: _____

E-mail: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____

Employer / Occupation: _____

Referred by: _____

Emergency Contact: _____

Relationship to Client: _____

Phone: Day _____ Night _____

Primary Care Physician: _____

To help maintain a safe exercise environment members must follow these policies:

1. All members are encouraged to complete a fitness assessment and instruction before participating in the wellness program.
2. We do not provide child care. Children younger than 12 are not allowed in the facility, unless they are involved in a specific wellness program.
3. Proper attire should be worn: comfortable clothes and walking or athletic shoes are required.
4. Place all dirty towels/wash cloths in hampers provided in the locker rooms.
5. Wipe off all equipment with a towel after use.
6. Limit time on cardiovascular equipment to 20 minutes if others are waiting.
7. Please do not adjust the TVs - ask a staff member for assistance.
8. All members are asked not to wear strong perfumes or cologne.
9. All members must be able to function independently of staff members.
10. We reserve the right to refuse service at any time to any person failing to abide by our policies and procedures.

Signature: _____ Date: _____ Time: _____

Witness: _____ Date: _____ Time: _____

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NAME: _____ DATE: _____

Regular physical activity is safe for most people. However, some individuals should check with their doctor before they start an exercise program. To help us determine if you should consult with your doctor before starting to exercise with St. Joseph's/Candler Wellness Center, please read the following questions carefully and answer each one honestly. All information will be kept confidential.

PLEASE CHECK YES or NO:

QUESTION	YES	NO	COMMENTS
Do you have a heart condition, increased heart rate or palpitations?			
Do you feel pain in your chest brought on by physical activity?			
Have you ever had a stress test? If yes, when, and what was the result?			
Recent cardiac event within the last 12 months to include angioplasty, heart attack, or open heart surgery.			
Have you ever experienced a stroke?			
Do you have epilepsy?			
Do you ever lose consciousness or control of your balance due to chronic dizziness?			
Do you have emphysema, chronic bronchitis or other pulmonary conditions?			
Do you have congestive heart failure?			
Are you pregnant?			
Do you have any muscular or joint problems that restrict you from engaging in physical activity? If yes, are you currently being treated?			
Do you have a history of cancer?			
Has a physician ever told you or are you aware that you have high blood pressure?			
Has anyone in your immediate family (parents/brothers/sisters) had a heart attack, stroke, or cardiovascular disease before age 55?			
Has a physician ever told you or are you aware that you have a high cholesterol level?			
Do you have diabetes? Type I or Type II			
Do you currently smoke?			
Do you have peripheral vascular disease?			
Are you currently exercising LESS than 1 hour per week? If you answered no, please list your activities?			
Recent surgery or illness within the last 2 months?			

Patient Information

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Wellness Center
Health History Questionnaire

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St. Joseph's/Candler
Wellness Center
Health History Questionnaire

Please list all current medications.

NAME	DOSAGE	NAME	DOSAGE

What are your specific FITNESS goals at the WELLNESS CENTER?
(Indicate all that apply)

CHECK ✓		CHECK ✓	
	Increase strength and endurance		Improve flexibility
	Improve cardiovascular fitness		Improve muscle tone
	Reduce body fat		Increase muscle mass
	Exercise regularly		Injury rehabilitation
	Sports conditioning		Improve nutritional habits
	Reduce stress		Control cholesterol
	Control blood pressure		Achieve balance in life
	Stop smoking		Reduce back pain
	Improve productivity		Other

What are your specific HEALTH goals at the WELLNESS CENTER?
(Indicate all that apply)

INITIAL ✓		INITIAL ✓	
	Diabetes Management Center		Cardiopulmonary Rehabilitation
	Nutritional Counseling		Other
	Physical Therapy		
	Risk Reduction Program		

I have read, understood, and completed this questionnaire. Any questions that I had were answered to my full satisfaction.

Name _____ Date _____

Signature _____

STAFF USE ONLY

Cleared to exercise _____ Not cleared to exercise _____ Physician release given to client _____

Reason _____

HEALTHWAYS

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 Healthways 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 Healthways 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 Healthways 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 Healthways 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 Healthways participating location, any sponsoring organization, Healthways, 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 Healthways 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.

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 Healthways 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	