



Community Center at Christwood

<i>For Staff Use</i>	
Billing Start Date	
Joining Fee Amt.	
Pro-Rate Amt.	
Total	
Pro-Rate Month	
Begin Full Dues	
Mbership Type	S / C

Keytag # _____

Decal:

Membership Application Community Center 985-292-1234

The following information is confidential and will be handled with care. Personal health Records may be shared with your health care providers and/or with staff at Community Center at Christwood as needed. Accurate completion of the questions below is required for participation in a fitness assessment, exercise prescription, group exercise classes, or other services available at the Community Center.

Contact Information

Last Name		First Name		M.I.
Gender (M/F)	Age	Date of Birth		
Address			Apt.	
City		State	Zip	
Phone Number ()	Emergency Contact		Emergency Phone ()	

E-mail Address _____

How did you hear about us? _____

Current Medications

Name of Medication	Dose	How Often	Reason for Taking
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Are you allergic to any medication? Y N *If yes, explain:*

Personal History: *Do you have, or have you ever had, any of the following?*

Heart disease	Y	N	Dizzy spells	Y	N
Heart attack	Y	N	Unusual fatigue	Y	N
Heart surgery	Y	N	Recent or serious illness	Y	N
Disease of an artery	Y	N	Skipped or rapid heart beats	Y	N
Angioplasty	Y	N	Chronic swelling of feet or ankles	Y	N
Heart murmur	Y	N	Kidney disease	Y	N
Rheumatic Fever	Y	N	Liver disease	Y	N
Stroke	Y	N	Shortness of breath (unexplained)	Y	N
Claudication	Y	N	Asthma	Y	N
Phlebitis/Emboli	Y	N	Chronic bronchitis	Y	N
Thyroid Disease	Y	N	Emphysema	Y	N
Epilepsy	Y	N	Shortness of breath at night	Y	N
Cancer	Y	N	Vision Loss	Y	N
Memory Loss	Y	N	Hearing Loss	Y	N
Pain, discomfort (or other anginal equivalent) in the chest, neck, jaw, arms, or other areas due to ischemia				Y	N
Diagnosed with diabetes or have a fasting blood glucose of ≥ 110 mg/dL confirmed by measurements on at least 2 separate occasions				Y	N
High blood pressure (systolic blood pressure of ≥ 140 mm Hg or diastolic ≥ 90 mm Hg, confirmed by measurements on at least 2 separate occasions)?				Y	N
Are you currently taking blood pressure medication?				Y	N
Emotional disorders (depression, stress, anxiety, etc.)				Y	N
Eating disorders (trouble with digestion, poor appetite, bulimia, etc.)				Y	N
Parkinson's disease or any other neurological impairments				Y	N
<i>If the answer to ANY of the above is yes, please explain and give dates:</i>					

Cholesterol: *Please indicate your cholesterol profile over the last five years.*

Has your total serum cholesterol ever been >200 mg/dL?	Y	N	Unsure
Has your serum High Density Lipoprotein (HDL) cholesterol been <40 mg/dL?	Y	N	Unsure
Has your serum HDL cholesterol been >60 mg/dL?	Y	N	Unsure
Has your serum Low Density Lipoprotein (LDL) cholesterol been >130 mg/dL?	Y	N	Unsure
Are you on currently or have you been on a cholesterol-lowering medication?	Y	N	

Tobacco Use:

Do you currently use tobacco? Y N

Caffeine and Alcohol Consumption

Do you drink alcohol? Y N

If yes, how often/much: _____

Do you drink caffeinated beverages? Y N

If yes, how often/much: _____

Exercise: *Over the past six months, on average, please describe your level of physical activity.*

Number of days per week 1 2 3 4 5 6 7

Number of minutes per day 15 30 45 60+

Intensity Level Light Moderate Hard

Types of activity (please check next to all that apply):

- Aerobic Activity (walking, swimming, aerobics, etc)
- Weight Lifting (either with machines/dumbbells or in an aerobics class)
- Flexibility Training (yoga classes, stretching on your own)

Family History: *Do any of your immediate family members (parents, siblings or children) have or have they ever had any of the following?*

	Y	N	Who	Age at onset
Heart Attack	Y	N	_____	_____
Sudden Cardiac Death	Y	N	_____	_____
Coronary Artery Bypass Surgery Or Angioplasty		Y	N	_____

Orthopedics

Do you suffer from arthritis/swollen joints? Y N

If yes, please explain:

Have you ever suffered from a bone/joint injury or had a joint replacement? Y N

If yes, please provide relevant date(s) and affected joint(s):

Balance

How is your walking/balance? Poor Fair Good Excellent

Please explain:

Have you had any recent falls? Y N

If yes, please describe what happened:

Do you use a walker? Y N

Do you have trouble with stairs? Y N

Do you require the assistance of an aide? Y N

If yes, for what functions:

Hospitalization:

Have you been hospitalized with any illness or injury in the past 10 years? Y N

Year Reason

Pertinent Information

Is there any pertinent information regarding your health history that has not already been described? If yes, please explain: Y N

To the best of my knowledge, the information I have provided is accurate. I will agree to inform the Community Center staff of any changes in my health status.

Signature _____ Date _____