Stillwater Medical Center

Total **Health**

Phone: 533-4348 Fax: 624-6596

Member Information and Health History

Name: _____ Signature: _____ Date: _____

Step 1: Signs and Symptoms

Do you experience:

☐ chest discomfort with exertion
☐ unreasonable breathlessness
☐ dizziness, fainting, blackouts
☐ ankle swelling
☐ unpleasant awareness of a forceful, rapid or irregular heart rate
☐ burning or cramping sensation in lower legs when walking short distance
☐ known heart murmur

Step 2: Current Activity

Do you perform planned, structured physical activity for at least 30 minutes at moderate intensity on at least 3 days per week for at least the last 3 months?

☐ Yes ☐ No

Step 3: Medical Conditions

Have you had or currently have:

☐ a heart attack
☐ heart surgery, cardiac catheterization, or coronary angioplasty
☐ pacemaker/implantable cardiac defibrillator/rhythm disturbance
☐ heart valve disease
☐ heart failure
☐ heart transplantation
☐ congenital heart disease
☐ diabetes
☐ renal disease

Primary Care Physician: _____

***Did a Total Health gym member refer you to Total Health Fitness? If yes, please list them here: _____**

Evaluating for medical clearance:

- If client has any marks in **Step 1**, *medical clearance is required before joining*. No need to further evaluate Step 2 or 3.
- If no marks in Step 1…
    - If client marked **"yes" in Step 2 and marked anything in Step 3,** they may continue to exercise at light to moderate *intensity without medical clearance*. Medical clearance is still recommended before engaging in vigorous exercise.
    - If client marked **"no" in Step 2 and marked any statements in Step 3**, *medical clearance is required before joining.*

Health History Questionnaire

Total Health
1810 N. PERKINS RD. | 405.533.4348 | TH.STILLWATER-MEDICAL.ORG

Name: _____ Date of Birth: _____ Date: _____

Address: _____

City:_____ State: _____ Zip: _____

Phone (Cell): _____ Home: _____E-mail address: _____

In case of emergency, whom may we contact?

Name: _____ Relationship: _____

Phone (Cell): _____ (Home): _____

Health Care Provider: _____

Present/Past History

Have you had, or do you presently have any of the following? (Check if yes):

☐ Heart attack

☐ Any kind of heart disease or heart surgery

☐ Diabetes or prediabetes

☐ High blood pressure

☐ Low blood pressure

☐ Seizures

☐Muscle or joint problems

☐ Lung disease

☐ Chest pain

☐ Kidney disease

☐ High cholesterol

☐ Edema (swelling in ankles)

☐ Pain/discomfort in chest, neck, jaw, arms, or other areas

☐ Known heart murmer

☐ Cancer

☐ Rheumatic fever

☐ Recent operation

Continued on back

☐ Fainting/dizziness

☐ Temporary loss of clear vision or speech

☐ Intermittent claudication (severe calf cramping)

☐ Pain, discomfort in chest, neck, jaw, arms, or other areas

☐ Unusual fatigue or shortness of breath *at rest or with light activity*

☐ Palpitations or tachycardia (unusual strong or rapid heartbeat)

Family History

Have any of your first-degree relatives (parents, sibling, or child) experienced the following conditions? (Check if yes) In addition, please identify at what age the condition occurred.

☐ Heart attack
☐ Congenital heart disease
☐ High blood pressure
☐ High cholesterol
☐ Heart surgery
☐ Diabetes
☐ Other major illness_____

Briefly Explain checked items: _____

Activity History

1. Why have you decided to seek exercise guidance at this time? (please be specific)
   _____
   _____
2. Date of your last physical examination performed by a physician:_____
3. Do you participate in regular exercise program currently? ☐ Yes ☐ No
4. Can you currently walk 2 miles briskly without fatigue? ☐ Yes ☐ No
5. Have you ever performed strength training exercises in the past? ☐ Yes ☐ No
6. Do you have injuries that may interfere with exercising? ☐ Yes ☐ No
   If yes, briefly describe:_____
7. Do you smoke? ☐ Yes ☐ No
8. What is your body weight now?_____
9. What was your weight one year ago?_____
10. What was your weight at age 21?_____
11. List any medications you are currently taking:
    _____
    _____

I acknowledge that I will be using Total Health's facilities at my own risk and agree that Total Health shall not be liable to me as a member or my guests, for injury or harm incurred while involved in the use of equipment, facilities, or any activity sponsored by Total Health. I expressly acknowledge that I understand this paragraph to be a Waiver and Release of Total Health, it's agents, an/or employees from any liability for injury or harm incurred while involved in the use of equipment, facilities or activities at Total Health. This includes possible wet/slick floors and environments.

CONTRACT TERMS

- I have received a copy of the Rules and bylaws and agree to abide by them.
- I understand that the monthly membership plan is a continuous membership plan. The authorization will remain in full force and effect until Total Health has received written notice from the member of its termination.
- I understand Total Health may at any time adjust the monthly rate applicable to my category of membership. I understand that Total Health will give 30 days prior notice to any such charge.
- I understand that if my bank or credit card company, for any reason, does not honor my membership draft, I am responsible for said payment plus a service charge in addition to any bank service fee(s). Accounts 60 days past due will be cancelled immediately. Membership re-enrollment will be subject to payment of outstanding account balance and health enrollment fees.
- I understand requests for refunds or credits due as a result of information shown on bank statements must be made within 30 days from their statement date.
- I understand if I wish to terminate or change my membership in any way, I must provide Total Health with 30 days prior notice of such change. I agree to turn in all scan cards and pay all balances due in full upon termination of my membership.
- I understand the enrollment fee is non-refundable after 3 days.
- Cancellation: I understand to cancel or freeze my membership, I must make written notice and receive receipt confirmation.
- I understand that Total Health, upon receipt of notice of cancellation or freeze, has 30 days to stop bank payment and credit card drafts, regardless of the date of cancellation. Total Health does not reimburse for cancellations received after billing for that month has occurred.
- I and Total Health, acknowledge this Agreement contains the entire agreement of the parties and Total Health makes no warranties or representations, expressed or implied, other than those set forth herein. If any portion of this Agreement is held to be invalid or unenforceable, such portion shall be disregarded, and the remainder of the Agreement shall remain in full force and affect.
- I understand that PREPAID MEMBERSHIP are non-refundable for any reason and may not be canceled or place on freeze.

DRAFT AUTHORIZATION-Auto Draft Memberships only

For Bank/Credit Card paymentsI authorize my bank or credit card company to make my payment for monthly dues, any unpaid past dues, and any other fees, taxes or charges from the account shown above. I understand that Total Health reserves the rights to charge $20.00 to my account for any overdrafts that may occur and may, upon written notice, change the date that my monthly dues are debited from my account.

Signature: _____ Date: _____

Communication Check List

Cancelation and Freeze Requests

(For auto-draft memberships only)

✓ **1.** Request must be in writing

✓ **2.** Request must be received before the 1st of the month. Requests on the 1st of after will take effect the end of the month.

Paid In Full Memberships

✓ **1.** Are NON-REFUNDABLE

✓ **2.** May not be canceled or frozen. They have a set expiration date that cannot be changed.

✓ *I read this and agree!*

_____

Name and Date