



Langhorne, PA 19047-1295

St. Mary Wellness Center

Tel: 215-710-6861

Fax: 215-710-6931

## PLEASE READ CAREFULLY

*In order to design an exercise program that meets your individual needs, certain information regarding your health and physical condition is necessary. By answering the following questions, you will be helping us to provide you with an accurate strength and cardiovascular exercise program. Our instructors will review your responses, which are kept confidential.*

HAVE YOU OR ANY MEMBER OF YOUR FAMILY EVER BEEN A MEMBER AT THE WELLNESS CENTER?

YES

NO

LAST NAME

FIRST NAME

MIDDLE INT.

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
BIRTH DATE

\_\_\_\_\_  
AGE

M / F  
SEX

STREET ADDRESS

CITY

STATE

ZIP CODE

(\_\_\_\_\_)\_\_\_\_\_  
HOME PHONE

(\_\_\_\_\_)\_\_\_\_\_  
WORK PHONE OR PARENT WORK PHONE

PRIMARY PHYSICIAN

(\_\_\_\_\_)\_\_\_\_\_  
PRIMARY PHYSICIAN'S PHONE NUMBER

EMERGENCY CONTACT PERSON

(\_\_\_\_\_)\_\_\_\_\_  
EMERGENCY CONTACT PHONE NUMBER

ARE YOU AN EMPLOYEE OF SMMC: \_\_\_\_\_

*Thank you for choosing St. Mary as your Wellness provider. We are here to help you achieve the personal goals you have set for yourself through an individualized exercise program focused on your needs and objectives. Designed by a qualified member of our educated fitness staff, your personalized program supports your optimal health and safety at all times.*

*Here at St. Mary Wellness Center,*

***Our Commitment Is To You!***

**\*\*WELLNESS APPRAISAL QUESTIONNAIRE\*\***

**CATEGORY I: GENERAL HEALTH**

Please check those, which apply: Do you have a history of:

YES    NO

YES    NO

Diabetes

Gout

Phlebitis or Vascular Disease

Varicose veins

Coronary artery disease

Thyroid Disease

Renal Disease

Hyper Cholesterlomia

Have you had a medical illness or injury since your last check up or physical?

Explain: \_\_\_\_\_

Are you currently taking any prescription or nonprescription medication?

If yes, please list: \_\_\_\_\_

\_\_\_\_\_  
Have you ever been dizzy, or passed out during or after exercise?

---

---

**CATAGORY II: MUSCLE SKELETAL ASSESMENT**

YES    NO

Have you ever broken or fractured any bones? If yes, please list:

\_\_\_\_\_  
Have you dislocated any joints? If yes, please list:

\_\_\_\_\_  
Do your joints swell during or after exercise? If yes, please list:

\_\_\_\_\_  
Do you have a back condition?

Do you have a neck condition?

If yes, please check which (if applicable)                      Disc problem    Arthritis

Have you ever had any problems with pain in muscles, tendons, bones or joints during or after exercise? If yes, please check appropriate box and explain below.

Neck	Back	Shoulder	Knee	Ankle
Head	Chest	Upper arm	Elbow	Forearm
Hand	Wrist	Finger	Hip	Thigh
Shin	Calf	Foot		

Explain "YES" answer here: \_\_\_\_\_

Do you have any pre-existing medical conditions that would limit your ability to follow a basic exercise protocol? If yes, please explain:

---

---

**CATEGORY III: CARDIOVASCULAR**

Have you ever had a heart condition? If yes, please check those which apply:

YES    NO

Heart Murmur or other valve problem?

Other ( explain)\_\_\_\_\_

Has any member of your family been diagnosed with heart disease before the age of 60?

Have you ever experienced pain or tightness in the chest?

Have you ever had an abnormal EKG?

Have you ever had a stroke?

Has a physician ever denied or restricted physical activity for any heart problems?

Is your doctor currently prescribing medication for your blood pressure or a heart problem?

Have you ever had a heart attack (Myocardial Infraction)?

Do you have high blood pressure?

---

## CATEGORY IV: RESPIRATORY

Do you have a present lung condition?

If yes, please check those which apply:

YES	NO	YES	NO	YES	NO
		Tuberculosis		Persistent Cough	Asthma
		Pneumonia		Breathing Difficulty	Exercise induced asthma
		Do you smoke cigarettes?		For what length of time? _____	Packs per day? _____
				Recently quit smoking? Date ____/____/____	
		Have you ever had Rheumatic fever?			
		Do you cough, wheeze or have trouble breathing during or after activity?			

---

---

## CATEGORY V: WEIGHT MANAGEMENT

YES NO

Do you want to weigh more than you currently do?

Do you want to weigh less than you currently do?

Are you within 20 pounds of ideal body weight?

Are you 20 pounds above your ideal body weight?

---

---

## CATEGORY VI: STRESS MANAGEMENT

YES NO

Chronic medical problem?

Interpersonal problems? (marital, family, child, employer, friends)

Difficulty adhering to exercise plan?

Recent change in financial status?

Recent death of a loved one?

---

---

## CATEGORY VII: EXERCISE PROFILE

YES NO

Do you consider yourself to have a sedentary lifestyle?

Do you consider yourself to be in good shape?

Do you like to exercise?

Do you exercise a minimum of two times a week?

Do you feel as if you receive a thorough workout after exercising?

Is strength training your primary exercise type?

Is aerobic training your primary exercise type?

Is stretching a part of your exercise routine?

---

---

## CATEGORY VIII: PREFERENCES AND GOALS

1. When using strength training equipment for toning or strength gain, do you prefer:

Machines

Barbells/dumbbells

Aerobic conditioning classes

2. Please list your goals in order of importance, 1 being most important, 6 being least:

\_\_\_\_\_ Body fat reduction

\_\_\_\_\_ Overall body toning

\_\_\_\_\_ Overall body strength

\_\_\_\_\_ Preparation for a sport

\_\_\_\_\_ Cardiovascular conditioning

\_\_\_\_\_ Other \_\_\_\_\_

3. Are you involved in any recreational or competitive sports outside of the center? If yes, please

list: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

**\*\*VO<sub>2</sub> MAX TESTING\*\***

Cardiovascular fitness can be measured and individually programmed with VO<sub>2</sub> Max Testing. This test measures the O<sub>2</sub>/CO<sub>2</sub> exchange through respiration. A training schedule to develop aerobic capacity and or burn calories can be individually designed based on the results of this test.

**ACSM 1995 EXERCISE GUIDLINES**

The following guidelines have been developed by the American College Of Sports Medicine (ACSM) regarding eligibility for cardiovascular and exercise testing.

Check Any Of The Following Factors Below That Apply To You:

YES NO

Males 40 Years or older

Females 50 years or older

Myocardial infarction (MI) or sudden death before age 55 in father or other male first degree relative, or before age 65 in mother or other female first degree relative

Current cigarette smoking

Hypertension (<140/90 mm Hg without medication.

Hyper cholesterlomia ( total chol > 200 mg/dl or HDL < 35 mg/dl)

Diabetes mellitus

Sedentary lifestyle

**\*\*IMPORTANT NOTICE\*\***

**MEDICAL CLEARANCE**

If you have checked two or more ACSM risk factors, you must have your physician sign the physician clearance form before proceeding with the assessment profile, or have it faxed to us at (215) 710-6931.

With physician approval, you may be eligible for a VO<sub>2</sub> Max test.

**I HAVE READ, UNDERSTOOD AND COMPLETED THIS QUESTIONNAIRE. ANY QUESTIONS I HAD WERE ANSWERED TO MY FULL SATISFACTION.**

NAME : \_\_\_\_\_

(PLEASE PRINT)

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_

SIGNATURE OF PARENT/GUARDIAN: \_\_\_\_\_ ( For Members Under 18)

**\*\*YES TO FIVE OR MORE QUESTIONS\*\***

Talk with your doctor by phone or in person **BEFORE** you start becoming much more physically active or **BEFORE** you have a fitness appraisal. Tell your doctor about the Wellness Appraisal and to which questions you answered yes. You may be able to do any activity you want, as long as you start slowly and build up gradually. You may need to restrict your activities to those which are safe. Talk with your doctor about the kinds of activities you wish to participate in and follow his/her advice. Find out which community programs are safe and helpful for you.

**Financial Information**

By signing this form, I agree to the following:

- It is my understanding that I am responsible for payment, in full, at the time of services rendered.
- I am responsible for the Initial Evaluation fee on the day of the evaluation, or for the Walk-Thru.
- I will continue to pay the one month membership fee on a timely basis unless I submit written notice to St. Mary Wellness Center indicating otherwise.
- Installments are acceptable. The member is responsible to pay each month on a timely basis.
- Payments are Non-Refundable, unless extreme circumstances arise.
- I have been explained the fees and I am aware of all the costs involved pertaining to the fitness program.
- I will be responsible for any bills that need to be sent to Worker's Compensation or Auto Insurance. Membership and any cost associated with Wellness Center will be handled directly by member.
- I will notify staff member if I stop using the facility, otherwise, I will be responsible for payment in full.

**Release Form**

I understand that the purpose of this assessment procedure is to determine my current capacity to participate in an exercise program. I understand that the procedure is in no way intended to replace a physical examination by a physician, and that it is not intended, nor is it capable of, diagnosing illness or disability.

I understand that an instructor employed by St. Mary Wellness Center will present the results of the strength assessment to me. An exercise program will be developed based upon the results of my Assessment Profile, and will adhere to the guidelines of the American College of Sports Medicine as to the frequency, intensity and duration of exercise.

In consideration of the above, I assume risks and hazards incidental to participation in this assessment and program, and hereby waive, release, absolve, indemnify and agree to hold harmless, other than for willful default or neglect on their part, St. Mary Wellness Center employees or instructors.

\_\_\_\_\_  
**Member Name (Print)**

\_\_\_\_\_  
**Member Signature**

\_\_\_\_\_  
**Date**

If 18 or under needs to be signed by a parent or legal guardian.

\_\_\_\_\_  
**Parent/Legal Guardian**

\_\_\_\_\_  
**Date**

***For Staff Purposes Only***

Evaluation Date: \_\_\_\_\_

(Please check one)

\_\_\_\_\_ Eval Pending \_\_\_\_\_ Strength Eval \_\_\_\_\_ Comprehensive Eval \_\_\_\_\_ Eval Waved

Membership Category:

(please check those that apply)

\_\_\_\_\_ SMMC \_\_\_\_\_ SMMC +1 \_\_\_\_\_ SMMC +2 \_\_\_\_\_ SMMC +3

\_\_\_\_\_ Community \_\_\_\_\_ FAM +1 \_\_\_\_\_ FAM +2 \_\_\_\_\_ FAM +3

\_\_\_\_\_ Corporate \_\_\_\_\_ CORP +1 \_\_\_\_\_ CORP +2 \_\_\_\_\_ CORP +3

Employer \_\_\_\_\_

\_\_\_\_\_ Senior \_\_\_\_\_ Senior +1 \_\_\_\_\_ Coaching \_\_\_\_\_ Personal Training  
(62 and over)

\_\_\_\_\_ Student Membership Special Membership Category \_\_\_\_\_

\_\_\_\_\_ Auto \_\_\_\_\_ WC

Membership Cost: \_\_\_\_\_

Start Date: \_\_\_\_\_ End Date: \_\_\_\_\_

Evaluation Cost: \_\_\_\_\_

Extra Cost: \_\_\_\_\_

Total Amount Due:

Amount Collected: \_\_\_\_\_

Amount Owed: \_\_\_\_\_

**SPECIAL COMMENTS:**

---

---

---

---

---

---

---

Staff Initials: \_\_\_\_\_