Performance Physical Therapy Fitness Center
Health / Medical History Questionnaire

Name _____

Do you now or have you ever smoked? ☐ Yes ☐ No

If you previously smoked, how many years did you smoke? _____

How often did you smoke? _____

How long ago did you quit? _____

Do you consider yourself: *(check one)*

☐ Sedentary ☐ Light exercise ☐ Moderately active ☐ Highly active

If active, what kind of exercise do you now do? _____

Would you characterize your life as: *(check one)*

☐ Highly stressful ☐ Moderately stressful ☐ Low in stress

Medical History -- Please check the boxes next to any of the following conditions you now have, or have experienced in the past.

- ☐ Heart attack, coronary bypass or other cardiac surgery
- ☐ Diabetes
- ☐ Stroke
- ☐ Peripheral vascular disease
- ☐ Phlebitis, emboli
- ☐ Rheumatic fever
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Chest discomfort
- ☐ Extra, skipped or rapid heart beats/palpitations
- ☐ Heart murmur
- ☐ Ankle swelling
- ☐ Cold hands or feet
- ☐ Unusual shortness of breath
- ☐ Lightheadedness or fainting
- ☐ Epilepsy, seizures
- ☐ Anemia
- ☐ Emphysema
- ☐ Bronchitis
- ☐ Pneumonia
- ☐ Chronic, recurring cough
- ☐ Increased anxiety or depression
- ☐ Emotional disorders
- ☐ Fatigue, lack of energy
- ☐ Difficulty sleeping
- ☐ Migraine or recurring headache
- ☐ Swollen, stiff, or painful joints
- ☐ Hernia
- ☐ Arthritis
- ☐ Bursitis
- ☐ Low back pain
- ☐ Other *(list)* _____

_____

Please explain any boxes you checked: _____

_____

Please list any prescribed medications you are now taking: _____

_____

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Please list any over the counter medications or dietary supplements you are now taking:

_____

Please list any illness, hospitalization or surgical procedure within the past two years:

_____

Please give date of last physical examination and results: _____

_____

Family History

Have any of your blood relatives had any of the following? *(Please check those that apply. Include grandparents, parents, aunts, uncles and siblings. Please list relative and age the incident occurred.)*

	Relation to you:	**At what age?**
☐ Heart attack	_____	_____
☐ Stroke	_____	_____
☐ Coronary disease	_____	_____
☐ Congenital heart disease	_____	_____
☐ High blood pressure	_____	_____
☐ Diabetes	_____	_____
☐ Coronary operations	_____	_____
☐ Elevated cholesterol	_____	_____

Fitness Goals

Please check / describe specific goals and rate their importance.

__ Improve strength	__ Increase energy	__ Improve flexibility
__ Improve cardiovascular fitness	__ Improve muscle shape / size	__ Lose body weight / fat
__ Gain weight / muscle	__ Rehabilitate injury	__ Injury prevention
__ Improve diet / eating habits	__ Reduce stress	__ Stop smoking / drinking

__ Additional goals (list): _____

_____

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WAIVER AND ACKNOWLEDGEMENT

IN CONSIDERATION for the right to enter and remain on the premises of PERFORMANCE PHYSICAL THERAPY and FITNESS for observation, exercise, therapy, or other use, the undersigned agrees as follows:

1. I acknowledge that I have been advised to seek the medical advice of a physician prior to engaging in any program of exercise.

2. I have examined any equipment prior to use and found it to be in good working order. If it is not in good working order, I will not use it.

3. I assume all risk of injury or death from exercise and will not hold Performance Physical Therapy and Fitness liable or otherwise responsible for my injury or death resulting from exercising or an exercise program. I waive any claim that I may have against Performance Physical Therapy and Fitness from my injury or death as a result of using the facilities, exercising, or remaining, on the premises.

IN WITNESS WHEREOF, the undersigned, having read and understood the above does hereby voluntarily set his or her hand.

SIGNATURE:_____ DATED: _____

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Evaluation: $150.00 $75.00 Fitness Number _____

Monthly Fee:	$55.00 single	Student Summer Break Special	$110/3 months
	$50.00 family	Student Winter Break Special	$55/2 months
Annual Rate:	$550.00 single		
	$500.00 family		

Evaluation plus First Month's Fee $_____ = Today's Total $_____

FITNESS MEMBER INFORMATION (Please Print) DATE _____

Member Name _____ DOB _____ Age _____

Street Address _____

City _____ State _____ Zip _____

Phone _____ Email Address _____

Occupation _____ Work Phone _____

Family Doctor _____ Phone _____

How did you hear about us? _____

EMERGENCY CONTACT INFORMATION

1. Name _____ Phone (Daytime) _____

   Relationship _____ Phone (Evening) _____

2. Name _____ Phone (Daytime) _____

   Relationship _____ Phone (Evening) _____

I, the undersigned, understand that I am responsible for payments for membership to the fitness center by the first day of each month. I understand that if I choose to sign up for the automatic billing system that my membership fees will be automatically taken from my credit card each month. I understand that I am required to give notice in writing by the first day of the month for suspension or termination of this membership. Suspension or termination can not be done retroactively. The minimum amount of time that I can put my membership on hold is 30 days. By signing this, I agree to abide by all rules and regulations of the fitness center and Performance Physical Therapy, Inc. Performance Physical Therapy reserves the right to cancel any member. I agree to obtain clearance from my family doctor before participating in any form of exercise and in case of emergency you may contact the above listed people.

Signature _____ Date _____

Responsible Party _____ Date _____

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