YORK GENERAL
WELLNESS CENTER

Mon to Thurs: 5am – 9pm
Friday: 5am – 6pm
Saturday: 7am – 4pm
Sunday: 10am – 3pm

CONTACT INFORMATION

PARTICIPANT'S CONTACT INFORMATION

Name_____

Gender_____ Date of Birth _____/_____/_____ Age_____

Address_____
Street City, State, Zip Code

Home Phone _____ Cell Phone_____

Email _____

EMPLOYMENT

Name of Company_____

Position _____

Work Phone_____

EMERGENCY CONTACT (required)

Name_____Relationship_____Phone_____

PHYSICIAN INFORMATION

PERSONAL PHYSICIAN

Physician's Name_____ Phone_____

Clinic_____

Address_____
Street City, State, Zip Code

Date of last Physical Examination? _____

Have you ever had an EKG? If yes, when? _____

Have you ever had a Stress Test? If yes, when? _____

MEDICAL HISTORY

Please check the following if "YES"

PAST HISTORY

Have you had?

____Rheumatic Fever
____Heart Murmur
____High Blood Pressure
____Low Blood Pressure
____Disease of Arteries
____Varicose Veins
____Lung Disease
____Operation
____Injury to back, knees, ankles
____Epilepsy
____Diabetes
____Heart Attack
____Chest Pain
____Other Illness

PRESENT SYMPTOMS

Have you recently had?

____Chest Pain
____Shortness of Breath
____Heart Palpitations
____Cough on Exertion
____Coughing up Blood
____Back Pain
____Arthritis
____ Swollen Legs
____Use more than 1 pillow for sleep
____Awaken Short of Breath
____Other Illness

FAMILY HISTORY

Have any relatives had?

____Heart Attacks
____Heart Operations
____High Blood Pressure
____High Cholesterol
____Diabetes
____Congenital Heart Disease
____Other Major Illnesses

Please describe the above items checked "YES":

_____

_____

_____

SMOKING

Do you smoke? **No** **Yes** If yes, what and how much per day? _____

Age when you started_____ If you have stopped, how long ago? _____

& Why did you stop?_____

WEIGHT/MEDICATION

What was your weight at age 21? _____

Are you now dieting? **No** **Yes**

Type of Diet:_____

Please list (or attach) any current medications you are taking:

PHYSICAL ACTIVITY

JOB ACTIVITY LEVEL (Circle one) **Sedentary** **Active**

LIFESTYLE

Through adult life, do you feel you have been (check the one that best describes you)

_____Sedentary (sitting/little walking mostly at work)

_____A weekend or vacation exerciser

_____Physically active 1-2 times a week

_____Physically active 3+ times a week

How far do you think you walk each day? _____**miles** _____**minutes**

Do you have a regular exercise program at present? **No** **Yes**

If yes, describe:_____

_____

Do you take your pulse during your exercise routine? **No** **Yes** If yes, what is your average heart rate? _____

Does exercising, including climbing stairs, give you any of the following?

_____Chest pains
_____Pressure over the heart
_____Leg Aches
_____Shortness of breath
_____A tired feeling
_____Dizziness

Do you have any injuries that prohibits or interferes with exercising? **No** **Yes**

If yes, describe:_____

_____

Please list/describe any other pertinent medical or physical information:

PHYSICIAN'S CLEARANCE

MEDICAL CLEARANCE GUIDELINES

Because of the acute risks involved in participation in exercise classes, medical guidelines have been established by Kenneth Cooper, MD, from the Aerobic Center in Dallas, Texas. Dr. Cooper suggests:

Under 30:	You can start exercising if you have had a checkup within the past year and the doctor found nothing wrong with you.
30 to 39:	You should have a checkup within three months before you start exercising. The examination should include an electrocardiogram (EKG) taken at rest
40 to 59:	Same as for the 30-39 age group with one important addition. Your doctor should also take an EKG to check your heart while you are exercising. Your pulse rate during the test should approach the level it would during aerobic workouts.
Over 59:	Same as the 40-59 age group except that the examination should be performed immediately before embarking in any exercise program.

Please sign Part A **OR** Part B

Part A: PHYSICIAN'S CLEARANCE

After reading the foregoing guidelines, I have visited my physician. My physician and I agree that I am physically able to participate in the ______________________________ exercise program which is a low level exercise program monitored by heart rate and perceived exertion.

___________________________________ ___________________ ___________________________________

(Participant's Signature) **(Date)** **(Physician's Signature)**

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Part B: PHYSICIAN'S WAIVER

I understand the need for program entry guidelines and medical clearance. Even though my present health status may suggest a physician's clearance, I wish to participate in the _________________________ at my own risk. I agree to indemnify and hold harmless the instructor of the Wellness Center, facility, York General Hospital Wellness Program. In case of injury to myself, I hereby waive all claims against the organizers and/or instructors.

____ _____________________________

(Participant's Signature) **(Date)**

WAIVER

I, _____, (participant), hereby voluntarily agree to participate in a health and fitness assessment designed to collect certain information regarding my current health status as it relates to my participation in an exercise program. I agree to truthfully disclose to the best of my ability, accurate information about my health status and I assume all risks for inaccuracies. I understand that the assessment made and the fitness tests administered are in no way a substitute for an examination by my physician, do not serve diagnostic purposes, and are no guarantee that I am fit to exercise. The assessment and testing procedures I undergo are designed to:

1. Attempt to screen certain high-risk individuals from participation in an exercise program, who must first receive a physician's approval.
2. Provide information to the participant with regard to limitations and design of a fitness program for exercise.
3. Establish health and fitness baselines that would be used for evaluation purposes.

I understand that if I have any of the following conditions, I must receive my physician's approval before participating in an exercise program:

1. Respiratory disease
2. Uncontrolled high blood pressure
3. Insulin-dependent diabetes
4. Morbid obesity
5. Signs or symptoms of heart disease
6. Pregnancy
7. Seizure disorder

I understand my participation in any exercise classes or programs through the Wellness Center is in no way a substitute for the medical care rendered by my personal physician.

I am aware that the practice of exercise is not an exact science and I acknowledge that no guarantees have been made concerning the benefits or risks involved to me participating in such activity.

I agree to assume any and all risk involved in or arising for my use of the facility including, risk of death, bodily injury, the unavailability of emergency medical care, or the negligence or deliberate acts of another person. I further agree to hold York General Hospital, Inc., its officers, directors, employees, and agents completely harmless from any and all claims, causes of action, injuries, damages, costs or expenses arising out of my use of or presence upon York general Hospital Inc.'s property and facilities. I further agree to indemnify it from any and all claims, causes of action, damages, judgments, costs or expenses, including attorney fees, which in any way arise from my use or presence upon property and use of said facilities.

I am aware of the risks and possible discomforts that my participation in the program may bring on, such as:

1. Adverse body signs and symptoms
2. Muscle-joint soreness and/or injuries
3. Potential life-threatening cardio respiratory problems

If during the initial evaluation or participation in Wellness activities it is recommended that I consult my physician, I accept responsibility for doing so.

I agree to make every effort to utilize the facility and equipment properly and make every effort to apply the exercise principles that I taught. I understand that should my health status change or should my prescribed medications change, I must assume responsibility for informing the Wellness Center staff of those changes immediately.

I understand that a physician is not present during any component of this program. If physical injury should occur as a consequence of my participation in this program:

1. Basic first aid and CPR will be available to me
2. Expenses for medical care beyond immediate on-site first aid will not be assumed by the hospital or any of the staff

I am aware that I may elect not to participate, or that I may withdraw participation at any time letting staff members know, in writing, three business days ahead of the automatic withdrawal system.

I understand that if my blood pressure should exceed 160/100, I will not be allowed to exercise without a doctor's written permission.

I will also exercise within the prescribed THR (target heart rate) set for me by the staff. I agree to abide by all the policies and procedures of the Wellness Center.

All information obtained as a result of my utilization of the facility for participation in any programs would be treated as privileged and confidential. This information may be used for billing, statistical, or scientific purposes with my right of privacy mentioned.

This agreement shall be binding upon personal representatives, my successors, assigns and me.

(Participant's Signature) _____ (Date) _____

(Wellness Staff) _____ (Time) _____

WELLNESS CENTER POLICIES AND FEES

INTERVIEW AND ORIENTATION

Optional: Jump Start – Meet with a trainer and learn the machines that will work best for you. $35.00

Fitness Testing is offered, but not required as a part of your orientation. This is important to establish your current fitness status. Four different components of fitness will be checked. 1) Aerobic testing, 2) Muscular fitness, 3) Flexibility, and 4) Body composition. **Initial testing is no charge, subsequent testing will be $10.00 each session.** Testing will be done initially, (if so desired), then in 3 months, 6 months, and 1 year to check your progress.

Should you discontinue the program for a period of more than one year or have a medical condition requiring a revised exercise program, there is a **re-orientation fee of $10.00.**

WELLNESS CENTER PROGRAM FEES

Single Monthly Fee……..$34.00	55+ Monthly Fee……$30.00
Couple Monthly Fee……..$59.00	Senior Couple Monthly Fee……$53.00
Family Monthly Fee……$69.00	Corporate Monthly Fee……..$28.00

- Aerobic step/floor exercise classes are included in this fee.
- These fees apply for unlimited use of the exercise center whether you attend one time during the month or 30 times.
- Payment for the initial evaluation/orientation and first month's usage of the Wellness Center is due at the time of appointment.
- Participant may elect automatic withdrawal which will begin with the next payment.
- Participant may elect monthly or quarterly payments on the 30th of the preceding month. A written notice of at least 3 business days in advance of the 30th of the month is required to suspend that payment.
- Participants may pay one year membership. Reimbursement for annual payments will be granted with a medical release from a physician, less a $25.00 processing fee.

I, the undersigned, understand the above policy and am aware that I am financially responsible for such fees.

(Participant's Signature) _____ (Date) _____

(Wellness Staff) _____ (Date) _____