HALIFAX HEALTH

WELLNESS CENTER

APPLICATION INFORMATION

Attached is your application for membership to Halifax Health - Wellness Center. Please take time to fill out all of the information and return or fax these forms to the Wellness Center.

When you return these forms, you will be asked to pay a $35 commitment fee for the fitness evaluation and processing fee. This fee does not apply to Halifax Health Team Members.

Halifax Health - Wellness Center is a medical model for wellness and part of our membership offering is to screen for pre-existing risk factors that may contribute to health related diseases. Upon review of your application, we may require a physician referral for participation. This referral form can be faxed by us to your primary care physician.

> *NOTE: If you meet certain criteria as established by the American College of Sports Medicine such as diabetes, hypertension or smoking, your primary care physician may require you to take a physician monitored exercise stress test, prior to your participation in our program.*

When your application is received and the necessary processes are completed, you will be given an appointment to meet with one of the Wellness Center's exercise physiologists. During your initial appointment, you will be given a fitness evaluation that consists of tests for flexibility, strength, endurance, percentage of body fat, measurements and baseline pulmonary function. These tests will enable the exercise physiologist to design an exercise program specifically for you. Subsequent appointments will be scheduled for further instruction, as needed.

Membership Policy on Leave of Absence: Memberships may not be placed on a hold status due to personal leave. This includes, but not limited to: vacation, summer absence, personal time, etc. Memberships can be placed on hold for documented medical conditions.

If you have any questions concerning any of this information, please call Halifax Health - Wellness Center at 386.254.4031 or halifaxhealth.org/wellnesscenter.

FAX COMPLETED APPLICATION TO:

386.947.2982

HALIFAX HEALTH

Halifax Health - Wellness Center Membership Application

MEMBER #

PLEASE PRINT CLEARLY

Name (First and Last) _____ Male ☐ Female ☐ Date of Birth _____ Age _____

Address _____ City _____ State _____ Zip _____ Phone _____

Occupation _____ Work Phone _____

Emergency Contact Information

Name _____

Relationship _____ Work Phone _____

Address _____

City _____ State _____ Zip _____

Physician Contact Information

Name _____

Phone _____ Fax _____

Approximate Date of Last Physical Exam _____

Other Physician (cardiologist, pulmonologist) _____ Phone _____

RISK ASSESSMENT

The information requested below is required for the processing your application.

1. Have you been diagnosed with hypertension* or are you currently taking antihypertensive medication? ☐ Yes ☐ No
   ** Blood pressure ≥140mmHg systolic OR ≥ 90mmHg diastolic.*
2. Is your serum cholesterol ≥200mg/dl? ☐ Yes ☐ No ☐ I don't know
3. Is your fasting blood glucose ≥110mg/dl? ☐ Yes ☐ No ☐ I don't know
4. Are you currently a smoker or have you smoked cigarettes or cigars within the past six months? ☐ Yes ☐ No
5. Do you have diabetes mellitus? ☐ Yes ☐ No
6. Have you, your parents or siblings ever been diagnosed with coronary or atherosclerotic disease? ☐ Yes ☐ No
   If yes, what was the age of onset?
7. Have you been diagnosed with cardiopulmonary or metabolic disease? ☐ Yes ☐ No
8. Do you lead a physically active, non-sedentary lifestyle, i.e. vigorous exercise three times per week, laborious work? ☐ Yes ☐ No

Present Body Weight: _____ lbs.

Height: ____ ft. ____ in.

Systolic Blood Pressure: _____

Diastolic Blood Pressure: _____

PERSONAL DATA

1. List medications that you are currently taking. (Include dosage (mg) and the frequency that you take each medication):

MEDICATION	DOSAGE	FREQUENCY	MEDICATION	DOSAGE	FREQUENCY

2. List any drug allergies:

3. Do you currently experience lower back pain or have you in the past? ☐ Yes ☐ No ☐ I don't know

If yes, date of onset: _____ Diagnosis, if known: _____

4. List any special considerations or conditions that the Wellness Center staff need to be aware of:

5. List any special physical abilities that you wish to develop for either work or recreation:

6. Are you currently exercising on a regular basis? ☐ Yes ☐ No

7. Do you have any exercise equipment at home? ☐ Yes ☐ No

8. List specific goals that you would like to achieve as a member of the Wellness Center:

9. How did you learn about Halifax Health - Wellness Center?

HALIFAX HEALTH - WELLNESS CENTER

INFORMED CONSENT FOR EXERCISE TESTING & PROGRAM

I voluntarily desire to join Halifax Health - Wellness Center in order to improve my physical fitness and well being. In order to prescribe a level of exercise for me in my current state I hereby voluntarily consent to engage in a fitness evaluation and exercise prescription.

The fitness evaluation will include: blood pressure check, pulse, and oxygen saturation check, body fat percentage, measurements, flexibility, strength testing and a baseline spirometry.

During the exercise session, you will receive individual attention and instruction based upon the results of the fitness evaluation, screening process, and personal goals. Subsequent appointments will be made based upon that need.

The information, which is obtained, will be treated as privileged and confidential and will not be released or revealed to any person except the Wellness Center staff, without expressed written consent. The information obtained, however, may be used for statistical or research purposes with my right of privacy retained.

The exercise test and program is being performed pursuant to my request with my full knowledge, understanding and consent. I therefore release, acquit, and discharge Halifax Health and the Wellness Center staff from any and all liability of any damage or injuries I might sustain by reason of such exercise test or my participation in the Halifax Health - Wellness Center program.

Applicant's Signature _____ Date _____

Witness Signature _____ Date _____