

COMMENTS _____

FOR OFFICE USE ONLY

MEMBER NUMBER _____
Date Received _____
Circle Cash/Check/Charge \$ _____
Circle Automatic Debit Yes or No
Circle Medical Clearance Needed Yes or No
Date Cancelled _____

NIH Fitness Center Membership Application

Name _____
Last First Middle Initial

Payment: _____ **Initiation -- ALL MEMBERSHIPS** _____ **R&W Membership**

Single Payment --One Year

_____ Combination
_____ Aerobics
_____ Fitness Room

***Automatic Debit (Monthly Deduction)
one year minimum***

_____ Combination
_____ Aerobics
_____ Fitness Room

Temporary 3 or 6 month Memberships

_____ Combination # months _____ Expires _____
_____ Aerobics # months _____ Expires _____
_____ Fitness Room # months _____ Expires _____

Birth Date _____ Age _____ Sex: Male _____ Female _____

Office Address: Building: _____ Room: _____ Employer/ICD _____

Office Phone: () _____ E-mail Address _____

Home Address: _____

City, State, Zip Code: _____

Home Phone:() _____

HEALTH HISTORY

Physician Name: _____

Physician Phone: _____

Date of Last Physical: _____

Emergency Contact: _____

Relationship: _____

Phone (H): _____

(W): _____

MEDICAL HISTORY

Do you have or have you had any of the following condition:

(Please circle Y or N)

- | | | | |
|-----|--|---|---|
| 1. | Heart Attack | Y | N |
| 2. | Heart /Artery Disease | Y | N |
| 3. | Chest Pain | Y | N |
| 4. | Heart Palpitations/murmur | Y | N |
| 5. | Family History of Heart Disease | Y | N |
| 6. | High Blood Pressure | Y | N |
| 7. | High Cholesterol | Y | N |
| 8. | Smoking Habit | Y | N |
| 9. | Diabetes | Y | N |
| 10. | Lung Disease/Respiratory Condition | Y | N |
| 11. | Hypoglycemia | Y | N |
| 12. | Major Surgery | Y | N |
| 13. | Major Orthopedic Surgery | Y | N |
| 14. | Chronic Back Problems | Y | N |
| 15. | Fainting or lightheadedness | Y | N |
| 16. | Unusual Fatigue/Dizziness | Y | N |
| 17. | Shortness of Breath on Mild Exertion | Y | N |
| 18. | Asthma | Y | N |
| 19. | Arthritis/Bursitis | Y | N |
| 20. | Allergies | Y | N |
| 21. | Women -- Are you currently pregnant? | Y | N |
| 22. | Women -- Are you 50 years of age or older? | Y | N |
| 23. | Men -- Are you 50 years of age or older? | Y | N |

If you answered yes to any of the above questions, please explain:

List all drugs/medications you are taking and the reason:

1. _____
2. _____
3. _____

Are you aware of any allergies to any medications? ____N ____Y

If yes, please list: _____

LIFESTYLE PROFILE

BLOOD PRESSURE

1. Do you know your resting blood pressure? If yes: _____ / _____

SMOKING

1. Do you currently smoke? ____N ____Y
If yes, how many cigarettes per day (average) _____
How many years have you smoked? _____
2. Did you ever smoke? If yes, when did you quit? _____

WEIGHT

1. What is your present: Height _____ Weight _____
2. Are you following any diet? ____N ____Y
If yes, how long? _____
Name of Diet: _____ Calories/Day _____

CHOLESTEROL

1. Have you had your cholesterol checked within the last 12 months? ____N ____Y
Total cholesterol _____ LDL _____ HDL _____

CAFFEINE/ALCOHOL CONSUMPTION

1. Approximately your daily intake of:
_____ Cups of Coffee _____ Cups of Tea _____ Caffeinated Soda
_____ Beer _____ Glasses of Wine _____ Ounces of Liquor

STRESS/TENSION

1. How would you categorize your stress/tension level most of the time?
_____ Low _____ Moderate _____ High

How do you manage your stress? _____

PHYSICAL ACTIVITY

1. Are you presently exercising a minimum of 2 times a week for at least 20 minutes at a time? N Y

If yes, please list below the activity and duration:

- A. _____
- B. _____
- C. _____

2. What activities are you interested in participating in?

- | | | |
|---|--|---|
| <input type="checkbox"/> Strength Training | <input type="checkbox"/> Rower | <input type="checkbox"/> Recreation Leagues or Clubs |
| <input type="checkbox"/> Cross Trainer | <input type="checkbox"/> Treadmill | <input type="checkbox"/> Self Defense |
| <input type="checkbox"/> Stairmaster | <input type="checkbox"/> Airdyne | <input type="checkbox"/> Indoor Cycling |
| <input type="checkbox"/> Lifecycle | <input type="checkbox"/> Recumbent Bikes | <input type="checkbox"/> Yoga |
| <input type="checkbox"/> Aerobic/Body Shaping | <input type="checkbox"/> Kickboxing | <input type="checkbox"/> Pilates <input type="checkbox"/> Other _____ |

GOALS AND OBJECTIVES

What are your goals when joining the NIH Fitness Centers? (Be specific)

**I have completed this information to the best of my knowledge. I have not withheld any information that may affect the staff in designing a safe exercise program for me.

Signature _____ Date _____

Release of Liability

I, the undersigned, wish to participate in the activities and programs of the NIH Fitness Center. I certify that I am physically able to participate in any activity I take part in and will use good judgement while exercising. I recognize that I am responsible for knowing my own state of health, and I will advise the facility staff of any health problems related to exercise. I also understand I may be denied participation in activities for health reasons at the discretion of the staff.

I, the undersigned, so accept any and all responsibility and assume all risk of any injury or damage to my person that may arise, whether directly or indirectly as a result of my participation in the programs of the NIH Fitness Centers. I hereby release and discharge R&W and its respective officers and employees from all claims, damages, and liability whatsoever that may result from my injury or death, accidental or otherwise, during or arising from my utilization of the activities of the NIH Fitness Centers. I also agree that in the event of an injury while using the facilities, the Federal Employee's Compensation Act will be my sole provider of compensation. (Federal government employees only).

I agree to abide by the rules and regulations of the NIH Fitness Centers with the understanding that violation of such rules may result in withdrawal of my privileges to use the facility or in the programs offered.

I, _____, certify that I have read and that I understand the contents of this waiver.

Applicant Signature

Date