



HEALTH SUITE INTAKE FORM

_____ West Side Program _____ Tyvola Program

Date: _____	Start Date: _____
Name: _____	DOB: _____ Age: _____
Address: _____	City: _____ State: _____ Zip: _____
Phone #: _____	Cell Phone: _____
Emergency Contact: _____	Phone #: _____
Medical Doctor: _____	Phone #: _____

The following information is needed to satisfy the reporting requests of the agencies and organizations that fund our programs. All personal information will be kept confidential. Information reported to our funding agencies and organizations will be statistical in nature and will not have any identification markers.

Marital Status: Single Married Divorced Widowed Other

Ethnicity: African American Caucasian Hispanic/Latino American Indian Asian

Gender: Male Female Medicaid: Yes No

Annual Income: \$0 - \$10,001 \$10,001 - \$15,000 \$15,0001 - \$20,000 > \$20,000

Please list all current medication and supplements.

Current Medications	Name	Prescribed for
	_____	_____
	_____	_____
	_____	_____
	_____	_____
	_____	_____

Supplements	Name

Activity Level at Intake: Type of Activity: _____

Frequency of Activity: _____

Duration of Activity: _____

Entered into data base by: _____	Date: / /
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General Fitness Information/Release Form

You must sign #1 below and have your physician sign #2. This form is required of all who exercise in the Health Suite. This completed, signed form should be returned to the Health Suite Coordinator. Please call for your first appointment. Thank you.

1. Participant

Name: _____ Gender: Male Female

Address: _____

City: _____ State: _____ ZIP: _____

Phone #: _____ Date of Birth: _____

Emergency Contact: _____ Phone #: _____

I have volunteered to participate in a CMSC program of physical exercise. I hereby release the CMSC staff from any and all liability resulting from injuries which may occur during my participation in this program. The possibility of certain unusual changes in blood pressure, fainting, and heart disorders may occur. I hereby acknowledge and accept these risks. To my knowledge, I do not have any limiting physical condition or disability which would preclude my participation in a CMSC exercise program.

Participant's Signature: _____ Date: _____

For safety and liability reasons, the CMSC Health Suite Coordinator has the right to decline Health Suite service to participants even if the participant has a physician's signature.

2. Physician

I certify that there appears to be no reason why the CMSC exercise program should not be undertaken by the person whose name appears above.

Physician Signature: _____ Date: _____

Physician Name: _____ Phone #: _____

Recommendations/suggestions from the physician:

Please return to: Charlotte Mecklenburg Senior Centers, ATTN: Health Suite
Fax#: (704) 522-6444

*If you have any questions, please call (704) 817-5461

You will need to complete an orientation before exercising in the Health Suite. The orientation will be scheduled once all paperwork is completed received from participant and physician.

Release of Medical Information and Referral Form

1. Participant

Name: _____ Date of Birth: _____

Telephone #: _____

I _____ hereby authorize the release of the following information from my medical records to the Charlotte Mecklenburg Senior Centers, INC. for the purpose of participating in their structured exercise program.

Participant Signature: _____ Date: _____

2. Physician Information

Physician Name: _____

Address: _____ City: _____ State: _____ ZIP: _____

Telephone: _____ Fax: _____

3. Medical Professional

_____ This patient may participate fully in a physical activity program consisting of cardiovascular, strength and flexibility training without limitation.

_____ This patient may participate in a physical activity program with the following limitations and/or recommendations:

Please provide the following information from the last exam (if applicable):

Fasting Blood Glucose : _____

Total Cholesterol: _____

HDL: _____ LDL: _____

Triglycerides: _____

Blood Pressure: _____

Heart Rate: _____

Physician Signature: _____ **Date:** _____

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Fax#: (704) 522-6444

*If you have any questions, please call (704) 817-5461



PHYSICAL ACTIVITY READINESS QUESTIONNAIRE

Name: _____

Date: ____/____/____

Please answer each question accurately. If a question is answered with YES, please use the available space to explain your answer and give additional details.

1. Do you have high blood pressure? YES NO

2. Have you been informed by your doctor that your cholesterol is high? YES NO

3. Do you smoke? YES NO

4. Do you have diabetes? YES NO

5. Have you been told by your doctor that you have a heart condition and recommended only medically supervised physical activity? YES NO

6. Do you have chest pain brought on by physical activity? YES NO

7. Have you developed chest pain within the past month? YES NO

8. So you lose consciousness or fall over because of dizziness? YES NO

9. Do you have any orthopedic problems? YES NO

10. Do you take medications for blood pressure or heart conditions? YES NO

11. Are you aware of any reason you should NOT exercise? YES NO

12. Do you have difficulty exercising? YES NO

13. Have you had any type of surgery within the past three months? YES NO

PHYSICAL ACTIVITY READINESS QUESTIONNAIRE - (Pg. 2)

Name: _____

Date: ____/____/____

14. Do you have a history of lung problems? YES NO

15. Do you consider yourself overweight? YES NO

16. Have you ever been diagnosed with cancer? YES NO

17. Are you currently being treated for any chronic illness that is not covered by one of the questions above? YES NO

18. How would you rate your overall state of health? Excellent Good Fair Poor

19. Which of the following goals do you have?

- | | | |
|---|--|---|
| <input type="checkbox"/> Gain weight/muscle | <input type="checkbox"/> Improve flexibility | <input type="checkbox"/> Lose weight/inches |
| <input type="checkbox"/> Improve muscle tone/shape | <input type="checkbox"/> Improve strength | <input type="checkbox"/> Improve balance |
| <input type="checkbox"/> Increase energy | <input type="checkbox"/> Reduce stress | <input type="checkbox"/> Improve breathing |
| <input type="checkbox"/> Reduce pain from arthritis | <input type="checkbox"/> Improve blood cholesterol | |
| <input type="checkbox"/> Reduce blood pressure | <input type="checkbox"/> Improve blood sugar readings. | |
| <input type="checkbox"/> To do _____ without being winded or tired. | | |
| <input type="checkbox"/> Other _____ | | |



INFORMED CONSENT FOR PARTICIPATION IN AN EXERCISE PROGRAM

Name: _____

Date: ____/____/____

I hereby consent to voluntarily engage in an acceptable plan of exercise conditioning. I also give consent to be placed in program activities which are recommended to me for improvement of my general health and well-being. These may include an exercise prescription, stress reduction and health education activities. The levels of exercise, which I will perform, will be based upon my cardiorespiratory (heart and lungs) fitness. I will be given exact instructions regarding the amount and kind of exercise I should do. Depending upon my health status, I may or may not be required to have my blood pressure and heart rate evaluated during these sessions to regulate my exercise within desired limits. If I am taking prescription medications, I have already informed the staff and further agree to so inform them promptly of any changes which my doctor or I have made with regard to use of these. I will be given the opportunity for periodic assessments.

I have been advised to stop exercising if I experience symptoms such as fatigue, shortness of breath, chest discomfort or any other similar occurrences and to inform the program staff of my symptoms.

I understand that during the performance of exercise, a trained observer will periodically monitor my performance and perhaps measure my pulse, blood pressure or assess my feelings of effort for the purpose of monitoring my progress. I also understand that the observer may reduce or stop my exercise program, when any of these findings so indicate that this should be done for my safety and benefit.

Benefits to be Expected

I understand that this program may or may not benefit my physical fitness or general health. I recognize that involvement in the exercise sessions will allow me to learn proper ways to perform conditioning exercises, use fitness equipment and regulate physical effort.

Risks

It is my understanding that I have been so informed, that there exists the remote possibility during exercise of adverse changes, including abnormal blood pressure, fainting, disorders of heart rhythm and very rare instances of heart attack, stroke or even death, as well as other risks of injury or impairment due to my participation in activity. Every effort, I have been told, will be made to minimize these occurrences by proper staff assessment of my condition before each exercise session, staff supervision during exercise and by my own careful control of exercise efforts. I understand that there is a risk of injury, heart attack or even death as a result of my exercise, but knowing these risks, it is my desire to participate as herein indicated.

Confidentiality and Use of Information

I have been informed that the information, which is obtained in this exercise program, will be treated as privileged and confidential and will consequently not be released or revealed to any person without my express written consent. I do, however, agree to the use of any information which is not personally identifiable with me for research and statistical purposes so long as it does not provide facts which could lead to my identification. Only the program staff in the course of prescribing exercise for me and evaluating my progress in the program will use any other information obtained.

Freedom of Consent

I further understand that there are also other remote risks that may be associated with this program. Despite the fact that a complete accounting of all these remote risks is not entirely possible, it is still my desire to participate.

I acknowledge that I have read this document in its entirety or that it has been read to me if I have been unable to read same.

I consent to the rendition of all services and procedures as explained herein by all program personnel and to the provision of emergency care response and CPR if necessary.

Signature

Date

Witness

Date