



1700 Cogdell Blvd

Snyder, TX 79549

Phone: (325)574-7187 Fax: (325)574-1423

Name: _____ Gender: _____
Date: _____ D.O.B: _____ Age: _____
Address _____ Phone Number: _____

Regular physical activity is safe for most people. However, some individuals should check with their doctor before they start an exercise program. Please answer the following questions to help us determine if you should consult a doctor before starting to exercise. ALL INFORMATION WILL BE KEPT CONFIDENTIAL.

- | YES | NO | |
|-----------------------|-----------------------|--|
| <input type="radio"/> | <input type="radio"/> | 1. Do you have heart condition? |
| <input type="radio"/> | <input type="radio"/> | 2. Has your doctor ever told you only to do physical activity recommended by a doctor or do you have reason to believe that you should not do physical activity? |
| <input type="radio"/> | <input type="radio"/> | 3. Do you feel pain in your chest when you do physical activity? |
| <input type="radio"/> | <input type="radio"/> | 4. In the past month, have you had pains in your chest when you were not doing physical activity? |
| <input type="radio"/> | <input type="radio"/> | 5. Do you lose your balance because of dizziness or do you ever lose consciousness? |
| <input type="radio"/> | <input type="radio"/> | 6. Do you have a bone or joint problem that could be made worse by physical activity? |
| <input type="radio"/> | <input type="radio"/> | 7. Do you have high blood pressure that is not controlled? |

YES TO ONE OR MORE OF THE ABOVE INDICATES NEED FOR MEDICAL CLEARANCE PRIOR TO EXERCISE

- | | | |
|-----------------------|-----------------------|--|
| <input type="radio"/> | <input type="radio"/> | 8. Has anyone in your immediate family (parents, brothers, sisters) had a heart attack, stroke, or cardiovascular disease before age 55, even if he/she did not die? |
| <input type="radio"/> | <input type="radio"/> | 9. Are you aware that you have high cholesterol level? |
| <input type="radio"/> | <input type="radio"/> | 10. Do you currently smoke? |
| <input type="radio"/> | <input type="radio"/> | 11. Are you currently exercising less than one hour per week? |

YES TO TWO OR MORE OF THE ABOVE INDICATES NEED FOR MEDICAL CLEARANCE PRIOR TO EXERCISE

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12. Are you currently taking any medication? If yes, list medication(s) and purpose: _____

13. Are you allergic to any medications? If yes, please list: _____

In case of an emergency, contact: _____ **Phone:** _____

INFORMED CONSENT

I declare that I intend to use all or some of the facilities offered by Cogdell Rehab & Wellness.

I assume full responsibility, during and after my participation for my choices to use or apply, at my own risk, any portion of the information I receive.

I understand that part of the risk involved in undertaking any activity or program is relative to my own state of fitness or health and to the awareness, care, and skill with which I conduct myself in that activity or program. I acknowledge that my choice to participate in any activity, service, and program of this Fitness Center brings with it my assumption of those risks or results stemming from choice of fitness, health, awareness, care, and skill that I possess and use.

I further understand that some of the services, programs, and activities offered by the Fitness Center are sometimes conducted by individuals that may not be licensed, certified or registered instructors or professionals. I accept the fact the skills and competencies of some employee and/or volunteers will vary according to their training and experience and that no claim is made to offer assessment or treatment of any mental or physical disease or condition by those who are not duly licensed, certified, or registered.

I recognize that by participating in the activities, facilities, programs and services offered by the Fitness Center, I may experience potential health risks such as transient light-headedness, fainting, abnormal blood pressure, chest discomfort leg cramps, and nausea and that willfully those risks. I acknowledge my obligation to immediately inform the nearest supervising employee of any pain, discomfort, fatigue, or any other symptoms that I may suffer during and immediately after my participating in the activity.

I understand that I may ask any questions or request further explanation or information about activities, facilities programs, and services offered by the Fitness Center at any time, before during, or after my participation.

I have been informed of the Fitness Center Rules and Guidelines and I agree to adhere to them. I understand that I may be asked not to return if I fail to abide by the stated rules and guidelines.

I declare that I have read, understood and agree to the contents of this health history questionnaire and this informed consent in their entirety.

Signature

Date

If under 18, signature of Parent or Guardian

Date

Witness

Date