COLUMBIA athletic clubs

HEALTH STATUS QUESTIONNAIRE

PERSONAL INFORMATION:

Name:_____ Phone (hm):_____ (bus):_____

Address:_____ City:_____ State:____ Zip:_____

Occupation:_____ Male/Female: Age:_____ Height:_____ Weight:_____ Lbs.:_____

Emergency Contact:_____ Phone:_____ Relationship:_____

MEDICAL INFORMATION:

Physician's Name: _____ Phone #: _____

When was your last physical examination?: _____ Current Medications:_____

Does your physician know you are participating in this exercise program?:_____

DO YOU NOW, OR HAVE HAD IN THE PAST:

Cardiovascular History

- Heart attack, angina, chest pain, or stroke — Yes____ No____
- Increased blood pressure — Yes____ No____
- Breathing or lung problems,asthma,emphysema — Yes____ No____
- Recent surgery (last 12 months) — Yes____ No____
- High cholesterol — Yes____ No____
- Cigarette smoking — Yes____ No____
- Difficulty with physical exercise — Yes____ No____

Musculoskeletal History

- Chronic illness or condition — Yes____ No____
- Knee injuries — Yes____ No____
- Shoulder injuries — Yes____ No____
- Muscle, joint, back neck or spine disorders — Yes____ No____
- Arthritis — Yes____ No____

Medical History

- Pregnancy (now or within the last 3 month — Yes____ No____
- Diabetes — Yes____ No____
- Thyroid Condition — Yes____ No____
- Hernia — Yes____ No____
- Allergies — Yes____ No____
- Any condition that may be aggravated — Yes____ No____
- Advice from physician not to exercise — Yes____ No____

Please explain any Yes answers: _____

MEDICAL HISTORY:

1. Have you or a family member (parent, grandparent, sibling) ever experienced any of the following?

	You	Family	Who/When
High Blood Pressure	____	_____	_____
Heart Attack	____	_____	_____
Stroke	____	_____	_____
Heart/Murmur/Palpitations	____	_____	_____
Dizziness or Fainting	____	_____	_____
Thyroid Problems	____	_____	_____
Diabetes	____	_____	_____
Arthritis	____	_____	_____
Low Back Pain	____	_____	_____
Asthma	____	_____	_____

COLUMBIA athletic clubs

HEALTH STATUS QUESTIONNAIRE

MEDICAL HISTORY (CONTINUED):

2. Are you currently taking medications? Yes No
   If Yes, please list... _____

3. Do you currently have any injuries or pain? Yes No
   If Yes, please explain... _____

4. Do you spend more than 25% of your time each day: Mark all that apply.
   ____Sitting a desk ____Driving
   ____Lifting or carrying ____Standing
   ____Walking

5. Please mark the number of hours worked per week ____

6. Do you currently smoke? Yes _____ No _____
   If Yes, how many packs a day? _____
   If you smoked previously, when did you quit? _____

7. Do you exercise regularly? Yes _____ No _____

8. Are you interested in our weight management program, "My Life"? Yes _____ No _____

9. Please list anything specific you would like to discuss with a fitness trainer.
   _____
   _____
   _____

10. When was the date of your last physical examination? _____

11. Have you ever had injuries to the following? If Yes, please describe (how, when, etc.).
    ____Neck/Back/Lower back _____
    ____Ankle/Foot _____
    ____Knee/Leg _____
    ____Shoulder/Rotator Cuff _____
    ____Wrist/Hand _____
    ____Other _____

12. Are you currently being treated for an injury? If Yes, please describe.
    _____
    _____

13. Health and wellness information. (Please check any that you would like to learn about.)
    ____Nutrition
    ____Stress Management
    ____Injury Screening
    ____Sports Specific Clinics
    ____Pre/Post Natal Care
    ____Blood Pressure
    ____Massage Therapy
    ____My Life Weight Management
    ____Cholesterol Screening
    ____Body Composition
    ____Other

14. Exercise Interest. (Please check any activities that interest you.)
    ____Aerobics
    ____Basketball
    ____Triathlons/Marathons
    ____Squash
    ____Conditioning Clinics
    ____Personal Training
    ____Women on Weights
    ____Tennis
    ____Seniors on Strength
    ____Outdoor Club
    ____Racquetball
    ____Cycling
    ____Tai Chi
    ____Yoga
    ____Free Weights
    ____Lap Swim
    ____Youth Fitness
    ____Golf
    ____Men on Weights
    ____Flexibility/Stretching
    ____Group Personal Training
    ____Rowing
    ____Running
    ____Aquatic Exercise/Water Walking
    ____Indoor Cycling
    ____Kickboxing
    ____Pilates
    ____Body Building
    ____Other

Signature _____ Date _____

COLUMBIA athletic clubs

HEALTH STATUS QUESTIONNAIRE

LIFESTYLE INFORMATION:

1. Do you consider your diet balanced? _____
2. How would you describe your current level of stress? _____
3. Does your job require you to travel? ____ How often?_____
4. Were you a high school and/or college athlete? Yes ____ No ____
   If Yes, please explain: _____
5. Do you have any negative feelings toward or have you had any bad experiences with your physical activity programs? Yes ____ No ____ If Yes, please explain: _____
6. Do you often start exercise programs but then find yourself unable to stick with them? Yes ____ No ____
   If Yes, please explain: _____
7. How would you rate your current fitness level?
   ____ unfit ____ below average ____ average ____above average ____ very fit

Notes: _____

Signature _____ Date _____

Specialist _____ Date _____

COLUMBIA athletic clubs

INITIAL EVALUATION (PAGE 1 OF 2)

WEIGHT TRAINING OPTIONS:

☐ ActivTrax ☐ Personal Training ☐ Workout Card

EXERCISE HISTORY:

Required for ActivTrax Members only. Please select ONLY ONE option in each Exercise History category.

1. I have resistance training experience: ☐ Yes ☐ No (Go to Question 2)

If yes, I last resistance trained: ☐ Currently training ☐ 0-3 months ago ☐ 3-6 months ago ☐ 6 months ago or more

And, I consistently trained for: ☐ Less than 6 months ☐ More than 6 months

And, I usually resistance trained: ☐ 1-2 days/wk ☐ 3-4 days/wk ☐ 5+days/wk

2. I am familiar with this club's equipment: ☐ None at all ☐ Some ☐ Most ☐ All

3. I gauge my training experience level as: ☐ Novice ☐ Intermediate ☐ Advanced

FITTR PREFERNCES:

Required for ActivTrax Members only. Please select ONLY ONE option in each FITTR category.

(F) - Frequency (days per week): ☐ 2 Day ☐ 3 Day ☐ 4 Day

(I) - Intensity: ☐ Low ☐ Medium ☐ High

(T) - Training Type: ☐ Full Body ☐ Lower Body Only ☐ Opposing Muscle Groups ☐ Push/Pull ☐ Splitbody ☐ Super Slow ☐ Upper Body Only

(T) - Time of Each Workout (Approximate): ☐ 25-35 Minutes ☐ 35-45 Minutes ☐ 45-60 Minutes

(R) - Result Desired: ☐ Endurance ☐ Maintenance ☐ Mass Building ☐ Strengthening ☐ Tone, Shape, Define

NOTE: Certain combinations of the above FITTR settings may not provide adequate rest between workouts and are therefore disallowed.

ACTIVTRAX WORKOUT OPTIONS:

OPTIONAL - Default values will be used where no selection is made.

Use barbells in workouts: ☐ Yes ☐ No

Use dumbbells in workouts: ☐ Yes ☐ No

Experience level override: ☐ Level One ☐ Level Two ☐ Level Three

Use "Getting Acquainted" period: ☐ Yes ☐ No

MEMBER ACKNOWLEDGMENT:

By signing below, I acknowledge the following: (1) I have been presented the Terms of Enrollment; (2) I understand and agree with the Terms of Enrollment; (3) I agree to notify the club in writing if I choose to cancel my membership in this program.

Member's Signature _____ Date _____

COLUMBIA athletic clubs

INITIAL EVALUATION (PAGE 2 OF 2)

PERSONAL GOALS:

Personal Goal Selections

- Improve Cardio Fitness
- Improve Flexibility
- Improve Overall Health
- Improve Posture
- Improve Strength
- Increase Energy Level
- Lose Weight/Body Fat
- Maintain Figure/Weight
- Reduce Stress
- Self-Image/Confidence
- Shape, Tone & Define

Personal Goals Profile Goal Tracking is optional. Up to four goals may be tracked at any one time.

Member's Goals (Write member's selections in shaded areas)	Current Achievement Rating
	(less) 1 2 3 4 5 6 7 8 9 10 (more)
	(less) 1 2 3 4 5 6 7 8 9 10 (more)
	(less) 1 2 3 4 5 6 7 8 9 10 (more)
	(less) 1 2 3 4 5 6 7 8 9 10 (more)

In the Current Achievement Rating, ask the member the following question, and record the answer:
"On a scale from 1 - 10, 10 being fully achieved, where do you rate yourself with respect to accomplishing this goal?

MEASUREMENTS:

Measurements

Baseline Measurements	Heart Rates (RHR is necessary for ActivTrax prescribed cardio. To manually prescribe workout heart rates, complete the override fields.)										
	Resting Heart Rate*		bpm	Target Overrides:	L		M		H		
	Blood Pressure		/			Weight		lbs			

STRENGTH EVALUATION:

Strength Evaluation Ensure all exercises are performed using proper form. Try to achieve Momentary Muscular Failure (MMF) at the suggested number of reps.

Region	Exercise	Equipment Number & Name	MMF Reps		Weight, Pin #, or Reps			Seat / Other	
Chest	Seated Chest Press	Life Fitness Chest Press	8		Weight (lbs)		N/A		N/A
Back	Wide Grip Pulldown (front)	Life Fitness Dual Pulley Pulldown	8		Weight (lbs)		N/A	N/A	
Legs	Seated Leg Press	Life Fitness Seated Leg Press	8		Weight (lbs)		N/A		N/A
Shoulders	Seated Shoulder Press	Life Fitness Shoulder Press	8		Weight (lbs)		N/A		N/A
Back	Seated Back Extension	Life Fitness Low Back Extension	15		Weight (lbs)		N/A		
Abs	Crunch	Floor	# In 1 min.		# of Reps		N/A	N/A	N/A

COLUMBIA athletic clubs

CONSENT FORM

1. **Explanation of the Fitness Assessment**

   Cardiorespiratory Fitness: You will perform a submaximal exercise test on a bicycle ergometer. The exercise intensity will begin a low level and will increase through three stages according to your fitness level. Exercise intensity will peak at approximately 85% of maximum effort. The test will take 9-25 minutes and can be stopped at any time due to feeling of discomfort or fatigue.

   Body Composition: Skinfold calipers will be utilized to assess what percentage of your body weight is fat.

   Muscular Endurance: A maximum number of push-ups and sit-ups in a specified time may be evaluated as well.

   Flexibility: Evaluated through performance of the sit and reach test.

2. **Risks and Discomforts**

   The possibility exists for certain physiological changes to take place during the Fitness Assessment. These include abnormal blood pressure, fainting, irregular heartbeat, and in extremely rare instances, heart attack or death. These risks will be minimized through preliminary screening and observation during testing.

3. **Benefits to be Expected**

   The results of this test will be used to determine your current level of fitness level and will aid in the design of your exercise program.

4. **Inquires**

   Any questions about the procedures used in the Fitness Assessment are encouraged. If you have any questions or concerns, please ask for further explanation.

5. **Freedom of Consent**

   Your permission to perform this Fitness Assessment is voluntary. You are free to deny consent for any portion of this evaluation if you so desire.

I have read this form and I understand the test procedures that I will perform. I consent to participate in this test and I assume all risk the test may involve. I waive and release any and all rights and claims for damages that I may have against Juanita Bay Club and/or its employees for injuries which may be suffered by my participation in this Fitness Assessment.

_____ _____

Participant Signature *Date*

_____ _____

Fitness Specialist Signature *Date*

COLUMBIA athletic clubs

PERSONAL HEALTH HISTORY/ACTIVTRAX ADD MEMBER

BASIC INFORMATION:

☐ Mr. ☐ Ms. ☐ Mrs. ☐ Miss

First Name:_____ M.I.:____ Last Name:_____

Home Phone:_____ Club Member: ☐ New ☐ Current

Email Address*:_____

*Providing an email address is optional. However, it is REQUIRED to receive your username and password.

ADDITIONAL INFORMATION:

Address:_____ Address 2:_____

City:_____ State:_____ Zip:_____

Work Phone:_____ Mobile Phone:_____ Date of Birth (month/day/year):____/____/____

Contact Pref: ☐ Home ☐ Work ☐ Mobile ☐ Email

Coach:_____ Club Membership #:_____

The member's coach may be assigned or changed during the Evaluation.

MEDICAL INFORMATION:

Person to contact in case of emergency:_____ Relationship:_____ Phone #:_____

Physician's Name:_____ Phone #:_____

When was your last physical examination?:_____ Current Medications:_____

Does your physician know you are participating in this exercise program?:_____

DO YOU NOW, OR HAVE HAD IN THE PAST:

Cardiovascular History

- Heart attack, angina, chest pain, or stroke Yes____ No____
- Increased blood pressure Yes____ No____
- Breathing or lung problems,asthma,emphysema Yes____ No____
- Recent surgery (last 12 months) Yes____ No____
- High cholesterol Yes____ No____
- Cigarette smoking Yes____ No____
- Difficulty with physical exercise Yes____ No____

Musculoskeletal History

- Chronic illness or condition Yes____ No____
- Knee injuries Yes____ No____
- Shoulder injuries Yes____ No____
- Muscle, joint, back neck or spine disorders Yes____ No____
- Arthritis Yes____ No____

Medical History

- Pregnancy (now or within the last 3 month Yes____ No____
- Diabetes Yes____ No____
- Thyroid Condition Yes____ No____
- Hernia Yes____ No____
- Allergies Yes____ No____
- Any condition that may be aggravated Yes____ No____
- Advice from physician not to exercise Yes____ No____

Please explain any "Yes" answers:_____