Health History & Physical Activity Profile

HOW DID YOU HEAR ABOUT THE FITNESS CENTER?

Please circle

Co-Worker Building Sign Other (please specify) ______________________

Name: ______________________ Nickname: ______________________

Gender: Male Female Birth Date: ____________ Home Phone: ______________

Address: ____

Company: ________________ Department/Suite #: ______________

Email: ________________ Work Phone: ______________ Ext.______________

Physician Name: ________________ Physician Phone: ________________

In Case of Emergency

Name: ______________________ Relationship: ______________________

Home Phone: ______________________ Work Phone: ______________________

Cell Phone: ______________________

Office Use Only	Member #
Date Received:	Medical Clearance Required: Y N
Date Approved:	Medical Clearance Sent: / /
Date called for appt.	Medical Clearance Rec'd: / /
Assessment Date	Time of Assessment: AM PM

The Yards Athletic Club
Livestock Exchange Building
1600 Genessee, Suite 246
Kansas City, MO 64102
Phone: 816-221-4993
Fax: 816-842-5078
theyardsathleticclub.com

Directions: In order to service a safe and effective exercise program for you, we ask that you complete this form carefully. Failure to complete the required information in detail may result in a scheduling delay for your pre-membership assessment.

I **Age:** __________

II **LAST PHYSICAL EXAM:** Date: ______/_______

III **MEDICAL HISTORY - Please check if you have had any of the following conditions:**

Condition	Present	Past	Never	Comments
1. Heart Attack				
2. Any Heart/Artery/Peripheral Vascular Disease (any disorder affecting blood flow)				
3. Pain or discomfort in chest, neck, jaw, arms, other areas due to heart condition				
4. Irregular Heartbeat				
5. Heart Murmur				
6. High Blood Pressure &/or on Blood Pressure medication				
7. High Cholesterol/Triglycerides &/or on medication for this				
8. Stroke				
9. Lung Disease/Respiratory Condition				
10. Cancer				
11. Diabetes (Type 1 or 2)				
12. Cystic Fibrosis				
13. Thyroid Disorders				
14. Renal or Liver Disease				
15. Major Surgery w/in the last year				
16. Hypoglycemia				
17. Epilepsy/Convulsions				
18. Asthma				
19. Obesity				
20. Shortness of breath @ rest or w/ mild exertion				
21. Unusual fatigue/dizziness				

Condition	Present	Past	Never	Comments
22. Major Orthopedic Injury				
23. Back/Disk Condition				
24. Arthritis/Bursitis				
25. Gout				
26. Hernia				
27. Allergies				
28. Currently Pregnant				

Please list any serious or chronic illnesses you are aware of that are NOT listed above:

____

Please describe additional details of how any of the above conditions are controlled &/or if there are any restrictions:

____

Do you have any physical limitations that hinder or prevent you from exercising? YES NO

If yes, please describe: ____

IV FAMILY HISTORY

Has your father, mother, grandparent, or sibling(s) had, or currently have any of the following conditions:

CONDITION	YES	NO	WHO	At what age?
1. Sudden death due to heart attack or stroke				
2. Coronary Bypass				
3. Heart Attack				
4. Stroke				
5. High Blood Pressure				
6. Diabetes				
7. High Cholesterol/Triglycerides				
8. Cardiovascular Disease				
9. Cancer				
10. Osteoporosis				
11: Other:				

V CURRENT MEDICATIONS

1. Are you aware of allergies to any medications YES NO
   If yes, please list: ____
2. Please list any medications you have been on or presently taking:

	Type of Medication	Dosage/Frequency	How Long	Reason
A.				
B.				
C.				

VI LIFESTYLE PROFILE

Blood Pressure/Resting Heart Rate

A. Do you know your resting blood pressure? YES NO If yes: ________ / _______

B. Do you know your resting heart rate? YES NO If yes: _____________

C. How often do you monitor your blood pressure &/or heart rate?

Once a year Twice a year Once a month Once a week Other:

Smoking

A. Do you currently smoke cigarettes? YES NO

If yes, how many cigarettes per day (average)?________ How many years have you smoked? _____

B. Did you ever smoke cigarettes? YES NO

If yes, how many cigarettes per day (average)?________ How many years have you smoked? _____

C. If you have quit, what was the approximate date? _____/______

D. Do you smoke cigars/pipe? YES NO If yes, how many per day? _________

Height & Weight

A. What is your present: Height_________ Weight_________

B. What do you think is your "ideal" weight? _________

C. Are you following any diet? YES NO If yes, how long?

Name of diet: ______________________ Calories/Day:_________________

Cholesterol

A. Have you had your cholesterol checked with the last 12 months? YES NO

Total Cholesterol _________

LDL _______

HDL _______

Ratio _______

Caffeine/ Alcohol Consumption

Approximate your daily intake of: Cups/Ounces of Water __________

Cups of Coffee_______ Cups of Tea ________ Caffeinated Sodas _________

Beer (12oz.) _______ Glasses of wine (6oz.) ____ Ounces of liquor (1oz.)________

How would you rate your overall health?

Poor Fair Good Excellent

Are you physically active? YES or NO

If yes, please list your current activities

	Activity	Frequency per Week	Time per Session	How long Consistently
A.				
B.				
C.				

I understand that my participation in this activity is voluntary, and the activity carries some physical risk to me. I agree to assume the risk of any illness, injury or damage resulting from my participation in this activity. I hereby release and discharge The Yards Athletic Club/Livestock Exchange, LLC and their respective officers and employees from all claims, damages, and liability that I may have against any of them arising from the participation of me and my guests in this activity.

Signature: Date: