



Healthy Lifestyles Fitness Center Membership Information



A. Identification

Name: _____
Last Name First Name M.I.

Date of Birth: _____ Current Age: _____ Gender: M F

B. General Information

Registration Date: _____

Marital Status: M-Married W-Widowed D-Divorced S-Separated N-Single

Race: 01-African American 02-Hawaiian/Pacific Islander 03-American Indian/Alaskan 04-Asian
 05-White 06-Missing 07-Other 08-2 or more

Ethnicity: 01-Non-Hispanic 02 Hispanic 03 Missing

Number of people living in the household: _____

Voter Code: 01-Yes 02- No 03-Already Registered 04- Took Form Home 05- Declined

Wants to be on Mailing List? Y N

Physician's Name and Telephone Number _____

C. Address Information

Address: _____ County: _____

Address: _____ Home/Cell Phone: (____) _____

City: _____ Email: _____

State: _____ Zip: _____ May we contact you by email? Y N

IN CASE OF EMERGENCY, NOTIFY:

Name: _____ Relationship: _____

Address: _____

City: _____ State: _____ Zip: _____

Home/Cell Phone: (____) _____ Work Phone: (____) _____

General Membership Arthritis Exercise Program Life Beyond Cancer program Tai Chi

D. Health Information

1. Do you currently suffer from heart disease, stroke, diabetes, high blood pressure or high cholesterol? If yes, please indicate which one(s) and when first diagnosed _____

2. Check if you have a family history of any of the following:

Heart Disease Stroke Diabetes High Blood Pressure High Cholesterol

3. Have any relatives died suddenly of heart disease without prior warning or knowledge?

Yes No If yes, who was it? _____

4. List any relevant surgeries:

Procedure Name

Date

Procedure Name	Date

5. List any recent injuries: _____

6. List current medications:

Name of Medication

Purpose

Name of Medication	Purpose

Smoking History:

Do you smoke? Yes No

How much did/do you smoke a day? _____

How long have you been smoking? _____ If quit, when? _____

Exercise History

Do you presently engage in physical activity? Yes No

What kind? _____

How hard? Light Medium Hard How often? _____

Is your occupation: Sedentary Active Heavy

Do you have discomfort, shortness of breath or pain with exercise? Yes No

If yes, with what type of exercise? _____

Stress:

Do you consider your day stressful? Yes No

What is the nature of your stress? _____

How many hours do you sleep per night? _____ Is your sleep sound? Yes No

Cancer:

Have you ever been diagnosed with cancer? Yes No

When were you first diagnosed with cancer? _____ What type of cancer? _____

Did you undergo surgery? Yes No If yes, what type and when? _____

Did you undergo a node dissection? Yes No If yes, where? _____

Did you, or are you currently undergoing chemotherapy? Yes No If yes, when did you begin your treatment and when did/will it end? _____

Did you, or are you currently undergoing radiation therapy? Yes No If yes, when did you begin your treatment and when will it end? _____

Did you undergo a bone marrow transplant? Yes No If yes, when? _____

Have you undergone, or are you currently undergoing hormonal therapy? Yes No If yes, what type? _____

Have you experienced any side affects from any of the treatments you have undergone?

Yes No If yes, please describe: _____

Have you worked with a physical therapist since your surgery? Yes No

If yes, when did you begin and end your therapy? _____

What is the name, address and telephone number of your physical therapist? _____

Have you been diagnosed with lymphedema? Yes No

If yes, where? _____

**Healthy Lifestyles Fitness Center
Waiver and Release Form**

In consideration of being permitted to participate in the following service, sponsored by the County Commissioners of Cecil County, its elected and appointed officials, officers, agents, employees, and volunteers (herein called the Cecil County Government), **Healthy Lifestyles Fitness Center** and any services, class or activity offered through Senior Services & Community Transit (herein called course/activity), I understand and agree that:

1. I acknowledge that I have been advised of medical risks that may result from such participation and I represent to Cecil County Government that I have consulted my personal physician or other health authority and am physically capable of such participation without injury.
2. I recognize the risks of illness and injury inherent in any activity and am participating in the course/activity upon the express agreement and understanding that I am hereby waiving and releasing Cecil County Government, its elected and appointed officials, officers, agents, employees and volunteers from any and all claims, costs, liabilities, expenses or judgments, including attorneys' fees and court costs (herein, collectively referred to as "Claims") arising out of my participation in the aforesaid course/activity or any illness, injury or death resulting therefrom, and hereby agree to indemnify and hold harmless Cecil County Government from and against all such Claims except Claims proximately caused by the gross negligence or willful misconduct of Cecil County Government.
3. I understand that the **Healthy Lifestyles Fitness Center** staff reserves the right to exercise professional discretion when determining appropriate membership status. I recognize that all individuals may not be best served by joining the Healthy Lifestyles Fitness Center. *Further, I understand the **Healthy Lifestyles Fitness Center** is not a medically based fitness center, nor is it to be considered a physical therapy facility or a substitute for a prescribed therapy program.*
4. I hereby execute and deliver this waiver and release voluntarily and with full understanding of the contents and consequences thereof and to induce Cecil County Government to participate in this program.

Signature of Participant	Date	
Print Name of Participant		
Street Address		
City	State	Zip Code
Home Phone	Work Phone	

INFORMATION RELEASE FORM

Some of the information collected in this form may be shared with the Maryland Department of Aging (MDoA) and Senior Services & Community Transit (SSCT).

The **Healthy Lifestyles Fitness Center** and SSCT **will not voluntarily share any personal information which identifies you (such as your name, address or telephone number) with any other person or organization.** However, the **Healthy Lifestyles Fitness Center** and SSCT may use information such as attendance, increased strength, improved wellness, etc. for research and funding purposes or to support the premise of healthy, active aging within the community. All personal information will be kept in a secure location to protect your privacy.

You may refuse to share certain specific identifying information on this form.

You may inspect your personal information at the **Healthy Lifestyles Fitness Center**, 200 Chesapeake Blvd., Elkton, MD 21921 (410-620-3101),

I have read the above notice and give my consent for the Healthy Lifestyles Fitness Center to share information with SSCT and/or MDOA for the exact purposes mentioned above.

Signature

Date