JUMP START REGISTRATION FORM & MEDICAL HISOTRY

All information provided is confidential.

Client Information

Name:_____ Date of Birth:_____

Address:_____

(city)_____ (state)_____ (zip)_____

Phone #: (home)_____ (work)_____ (cell)_____

Email address:_____

_____ _____
Person to contact in emergency Relationship

_____ _____ _____
Home Phone Work Phone Cell Phone

_____ _____
Family Physician Phone

_____ _____
Other Physician (if applicable) Phone

How did you hear about us?

Friend:_____ Relative:_____ Was a previous patient:_____

Jump Start Member: _____ Name: _____

Newspaper: News-Sentinel: ____ Halls Shopper: ____ Metro Pulse_____

Radio:_____ List station:_____ TV:____ List channel:_____

Yellow Pages:_____ Senior Directory: _____

Insurance Company (Please List): _____

OTHER (Please List): _____

Interests

Gym _____ Pool _____

Personal Training _____ Arthritis water class _____

Yoga _____ Low Intensity water class _____

Strength Class _____ High Intensity water class _____

Weight Loss Program _____ Deep water class _____

Massage Therapy _____ Swim Lessons _____

If you plan to use the pool, can you swim? Yes_____ No_____
If you can't swim, are you comfortable in:
shallow water? Yes_____ No_____
deep water? (with a flotation device) Yes_____ No_____

Exercise History

Do you exercise regularly? Yes No

If yes, how many days per week do you normally spend at least 20 minutes in moderate to strenuous exercise?

0 1 2 3 4 5 6 7 days per week

What exercises do you currently participate in?

_____

_____

_____

What fitness goals do you have, or what do you want to happen by exercising here?

_____

_____

_____

Medical History

Date of
Last doctor visit:_____
Doctor's name:_____
Last medical physical exam:_____
Have you ever had a stress test?:_____
Have you ever had a physical fitness test?:_____

Circle anyone who had a heart attack or stroke, or who died of heart attack or stroke before age 60:

Father Mother Brother Sister Grandparent

Circle surgeries you have had and indicate the year:

Back_____ Eyes_____ Heart_____ Hip_____ Knee_____ Neck_____

Ears_____ Foot_____ Hernia_____ Kidney_____ Lung_____ Shoulder_____

Other _____

Please circle any of the following for which you have been diagnosed or treated by a physician or health professional:

Asthma	Diabetes II	Hepatitis C	Neck strain
Anemia	Emphysema	HIV	Obesity
Back strain	Epilepsy	Hyperlipidemia	Osteoporosis
Bleeding trait	Eye Problems	Hypoglycemia	Phlebitis
Bronchitis, chronic	Fibromyalgia	High Blood Pressure	Rheumatoid arthritis
Cholesterol	Gout	Incontinence	Stroke
Chronic joint pain	Hearing Loss	Kidney Problems	Thyroid problem
Coronary disease	Heart Attack	Lupus	Tuberculosis
Degenerative arthritis	Hepatitis A	Mental Illness	Ulcer
Diabetes I	Hepatitis B	Multiple Sclerosis	

Other_____

_____

List the medication(s) that you are currently taking or have taken in the last six months:

_____

_____

_____

(Any of these health symptoms that occur frequently is the basis for medical attention.) Use the key below to indicate how often you have each of the following symptoms:

5 = VERY OFTEN
4 = Fairly Often
3 = Sometimes
2 = Infrequently
1 = PRACTICALLY NEVER
N/A = Never

a. Cough up blood

N/A 1 2 3 4 5

b. Chest pain

N/A 1 2 3 4 5

c. Abdominal pain

N/A 1 2 3 4 5

d. Swollen joints

N/A 1 2 3 4 5

e. Low back pain

N/A 1 2 3 4 5

f. Feel faint

N/A 1 2 3 4 5

g. Leg pain

N/A 1 2 3 4 5

h. Dizziness

N/A 1 2 3 4 5

i. Arm or shoulder pain

N/A 1 2 3 4 5

j. Breathless with slight exertion
N/A 1 2 3 4 5

Health-Related Behavior

Do you now smoke? Yes No

If no, were you ever a heavy smoker? Yes No
If yes, when did you quit? _____

If you are a smoker, indicate number smoked **PER DAY:**

Cigarettes: 40 or more 20-39 10-19 1-9

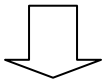
Cigars or pipes ONLY:
5 or more or any inhaled Less than 5, none inhaled

PAR-Q Form
Are you ready to exercise?

Regular physical activity is fun and healthy. Being more active is very safe for most people. However, some people should check with their doctor before they start becoming much more physical active. Please answer the following questions below honestly. It is important for us to know if you have any health conditions that can be affected by physical activity. **All information is confidential.**

Please circle "Yes" or "No" for each question honestly

Yes	No	1. Has your doctor every said that you have a heart condition and that you should only do physical activity recommended by a doctor?
Yes	No	2. Do you feel pain in you chest when you do physical activity?
Yes	No	3. In the past month, have you had chest pain when you were not doing physical activity?
Yes	No	4. Do you lose your balance because of dizziness or do you ever lose consciousness?
Yes	No	5. Do you have a bone or joint problem that could be made worse by a change in your physical condition?
Yes	No	6. Is your doctor currently prescribing drugs (for example, water pills) for your blood pressure or heart condition?
Yes	No	7. Do you know of any other reason why you should not do physical activity? If so, explain:_____



If you answered YES to one or more questions:

Talk with your doctor by phone or in person BEFORE you start becoming much more active. You might need a written permission from you doctor to allow you to participate.

I have read and understand this questionnaire and have answered all questions to the best of my knowledge.

Name (Print):_____ Date:_____

Signature:_____