
Screening Questions

Please answer each question and check all that apply.

1. Do you have any of the following risk factors for heart disease or stroke? **3 points each**
 Diabetes Obesity (more than 20 lbs. overweight) High blood pressure
 Smoking Family history of heart disease or stroke High cholesterol
 N/A

2. Have you ever had any of the following signs or symptoms of heart disease or circulatory disease? **3 points each**
 An abnormal EKG Rapid or irregular heart beat
 Pain or pressure in chest during or immediately following exercise, walking, or physical or sexual activity.
 As a result of walking several blocks experience severe pain in your calf (lower leg), which then subsides with rest.
 N/A

3. Have you had any of the following signs or symptoms of lung disease? **7 points each**
 Asthma / Bronchitis / Emphysema or any other lung condition
 Severe shortness of breath with activity. N/A

4. Do you take any heart or blood pressure medications such as Nitroglycerin, Lopressor, or Diazide?
 Yes (**7 points**) No

5. Have you ever experienced or do you have any of the following? (check all that apply) **11 points each**
 Coronary artery disease Angina (chest pain or pressure) Heart attack
 Heart valve problems Cardiomyopathy Pacemaker or ICD
 Congestive Heart Failure N/A

6. Are you pregnant? Yes (**11 points**) No N/A

7. If you are over the age of 40, has it been more than six months since you participated in active exercise? (Active is considered to be regular aerobic (cardiovascular) exercise, at least three times a week for a minimum of 20 minutes duration. Examples: Running, swimming, cycling, brisk walking or hard physical labor.)
 Yes No N/A

8. Please list any medications (prescriptions) that you take on a regular basis: _____

9. Are you aware of any reason, such as any musculoskeletal problems, arthritis, rheumatism, gout or injuries, not mentioned above, for limiting your participation in exercise/recreation activities and/or participation in a fitness evaluation? Yes No

If yes, please explain _____

Surgical history: _____

Total Points _____

If you have 11 points or more, you are required to complete the Physician Authorization section before you may participate

Informed Consent

You should be aware of the possible risk you might encounter by participating in fitness and recreation activities and/or participating in a fitness evaluation. The programs will be centered around activities that include running/jogging/walking, stretching, muscle strengthening and exercise using fitness equipment.

The most acute risk would be death caused from cardiac failure during exercise. Other medical problems that could result from your participation, but are not limited to: sore muscles, cramping, torn or pulled muscles, sprains, fractures, cartilage or ligament damage to major joints, nausea during exercise, rapid loss of weight and possible loss of appetite.

You may also incur some environmental risk if exercising outside, such as dog bites and traffic/pedestrian accidents. If you participate in water exercise, death from drowning would also be a risk.

Your participation is voluntary and you may withdraw at any time. Please give your consent with knowledge of the nature and types of exercise you will be doing and the discomforts/risk which may be encountered.

I have read the preceding warnings and risks and I have had an opportunity to ask questions and have them answered. I acknowledge that all information on this form is true to the best of my knowledge and I will inform the Health Strategies staff of any change in my health status, address and/or membership information. I hold harmless Health Strategies and Life Strategies Foundation from all claims on account of injury, which may be sustained when participating in fitness and recreation activities and/or participating in a fitness evaluation.

Signature **(If under 18, signature of parent or guardian)**

Date

Print Name

Phone

Address

City

State

Zip

Exercise Your Right To Good Health!

Physician Authorization

If you have scored **11 points or more**, based on your answers to the Screening Questions, you are required to get a written authorization from your physician before you may utilize Health Strategies Well Club. Please take this form to your personal physician for authorization.

Note to Physician

Health Strategies Well Club welcomes your patient's participation in our programs. Our programs are self-directed. If this applicant needs a medically supervised program, Health Strategies Clinical Services offer supervised programs. When requested, we do give general advice and instructions on exercise, equipment and the use of our facility. Please complete the following information regarding your patient. If there are any questions or concerns, please feel free to call us at 316-651-8015.

Diagnosis: _____

Limitations to exercise: _____

Special Instructions: _____

With the understanding that participation in fitness programs and services offered through the Health Strategies Well Club (fitness center) are *not medically supervised*, I have evaluated this applicant and approve his/her participation. Any exercise limitations/precautions have been listed above.

Physician Signature

Date



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