

# Health History Questionnaire

Please check one of the following:      **HFC Member**       **Non-Member**

**Exercise Program:** \_\_\_\_\_

In order to receive optimal benefit from your exercise program, it is important for the Fitness Specialist to be aware of any recent or chronic medical conditions you have. The Fitness Specialist will want to discuss each condition you checked below. Be sure to inform the Fitness Specialist if you are undergoing treatment or taking medication for any conditions. There are certain conditions that require you to consult a physician **BEFORE** participating in a guided exercise program. It is your responsibility to obtain medical clearance from your physician before participating in any activities or programs. Please complete this questionnaire to the best of your knowledge. Your health and safety are our priority.

Name \_\_\_\_\_ Birth Date \_\_\_\_\_ Age \_\_\_\_\_

Address \_\_\_\_\_ City/State \_\_\_\_\_ Zip \_\_\_\_\_

Phone (home) \_\_\_\_\_ (cell) \_\_\_\_\_ E-mail \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_

Gender: Male  Female

## General Information

Physician Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Do you exercise regularly or participate in any sport? Yes  No

Do you have any medical conditions that we should be aware of prior to engaging in physical activity? If yes, please describe below. Yes  No

Indicate your daily level of stress.      Mild       Moderate       High       Extreme

Describe any surgeries or injuries you have had and give relevant dates.

Please review each condition below and check the appropriate box.

CONDITION	YES	NO	CONDITION	YES	NO	CONDITION	YES	NO
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Heart Related Illness	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Pulmonary Related Illness	<input type="checkbox"/>	<input type="checkbox"/>
Musculoskeletal Injuries	<input type="checkbox"/>	<input type="checkbox"/>	Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Joint Replacement	<input type="checkbox"/>	<input type="checkbox"/>	Pregnancy	<input type="checkbox"/>	<input type="checkbox"/>	Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Low Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
Muscle Pain/Cramping	<input type="checkbox"/>	<input type="checkbox"/>	Surgery (<12 mo)	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
			Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Circulatory Issues	<input type="checkbox"/>	<input type="checkbox"/>
			Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Other	<input type="checkbox"/>	<input type="checkbox"/>

Additional Information: \_\_\_\_\_  
\_\_\_\_\_

**If you are participating in an exercise program, the following will apply:**

**Making the Most of Your Appointment**

Please arrive 5 – 10 minutes prior to your scheduled appointment to allow time to check-in, visit the locker rooms and prepare for your session. Payment should be made at the Front Desk.

**Method of Payment**

Cash, house charge, credit card (Master Card or Visa), and check made payable to either the Lake Forest or Lindenhurst Health & Fitness Center are accepted.

**Cancellation Policy**

To cancel an appointment, you must call at least 24 hours before your scheduled appointment time. No-shows and late cancellations will be charged the full-rate, so please schedule your appointment carefully.

**Policies and Procedures**

Each participant must read and sign an Informed Consent, Health History Questionnaire and Physician’s Authorization (if applicable) *before* participation in any of our fitness programs.

**Informed Consent for Participation**

You hereby agree to participate in a supervised fitness service at the Health & Fitness Center (HFC). You recognize that if you participate in any on-site fitness services, and use the locker room facilities, you will be doing so at your own risk. You agree to comply with the rules and regulations established by HFC staff. You understand that any infraction of the rules or regulations could result in the forfeiture of your appointment and possible denial of access to HFC.

You understand that all Personal Training, Pilates or Wellcoaching sessions, Fitness Assessments and Group Exercise/Wellness classes are provided by Certified Personal Trainers, Wellcoaches and Group Exercise Instructors for the purpose of weight loss and to improve strength, cardiovascular health, range of motion and overall well-being. You further understand that Personal Trainers, Wellcoaches or Instructors do not diagnose illness; disease or any other physical or mental disorder; prescribe medical treatment or pharmaceuticals; or perform any spinal manipulations. Information exchanged during any service session is educational in nature and intended to help you become more familiar with and conscious of your own health status. Because our fitness staff must be aware of existing physical conditions, you have stated all your known medical conditions and take it upon yourself to keep the fitness staff updated on your physical health. With this in mind, you agree to participate in a supervised exercise service and hold the fitness staff harmless for any problems that might arise.

You acknowledge that your attendance at or use of HFC including, without limitation your participation in any of HFC’s programs, services or activities and your use of HFC’s equipment and facilities could cause injury to you. In consideration of your program enrollment at HFC, you hereby assume all risks of injury which may result from or arise out of your attendance or use of HFC or its equipment, activities, facilities or transportation; and you agree, on behalf of yourself and your heirs, executors, administrators and assigns, to fully and forever release and discharge HFC and the Lake Forest Hospital Foundation and their respective officers, directors, employees, agents, successors and assigns, and each of them collectively (collectively the “Releases”), from any and all claims, damages, demands, rights or action or causes of action, present or future, known or unknown, anticipated or unanticipated, resulting from or arising out of your attendance at or use of HFC or its equipment, activities, facilities, services or transportation, including without limitation any claims, damages, demands, rights of action or causes of action resulting from or arising out of the negligence of the Releases. Further, you hereby agree to release and discharge the Releases from any and all liability for any loss or theft of, or damage to, personal property.

By signing below you acknowledge that you have carefully read this waiver and release and fully understand that it is a waiver and release of liability. This waiver shall be binding on you, your spouse, your children, legal representatives, heirs, successors and assigns.

\_\_\_\_\_  
**Signature** \_\_\_\_\_  
**Date**

By signing below you acknowledge that you chose not to disclose your health history information.

\_\_\_\_\_  
**Signature** \_\_\_\_\_  
**Date**



Lake Forest | Lindenhurst  
Health & Fitness Centers

## **Lake Forest Health and Fitness Center** of Northwestern Lake Forest Hospital

### **Authorization for Release of Information**

I authorize Lake Forest Health and Fitness Center to release medical information to any physician treating me during this visit or subsequent visits and to my primary care physician. This authorization for release of information is effective during my term of membership at Lake Forest Health and Fitness Center.

### **Authorization to Request Medical Information**

I authorize Lake Forest Health and Fitness Center to request medical information from any physician treating me during this visit or subsequent visits. This authorization is effective during the term of my membership at Lake Forest Health and Fitness Center.

### **Research and Confidentiality**

The information obtained during my evaluation or treatment will be treated as privileged and confidential and will not be released or revealed to any person without my expressed written consent. All information obtained while enrolled at Lake Forest Health and Fitness Center programs or clinics may be used for statistical or scientific research purposes. I may be contacted to obtain follow up information after completion of the program, fitness assessment or clinic with Lake Forest Health and Fitness Center. I may refuse or withdraw consent at any time.

---

Member Signature

---

Date