CentraState
Fitness & Wellness Center

Emergency Information

Name: (Last) (First)			Date:
Address: (City) (State) (Zip)			
Cell Phone:	Email:	Age:	Gender:
Date of Birth:		Occupation:	

Emergency Contact	
Name:	
Relationship:	Phone:
Additional Contact Person:	Phone:

Physicians Name (List name & type of doctor that is treating you, or prescribing your medications)	
Name:	Specialty:
Name:	Specialty:
Name:	Specialty:

Physical Activity Readiness Questionnaire (PAR-Q)

Please read the 7 questions below carefully & answer each one honestly.	Yes	No
1. Has your doctor ever said that you have a heart condition ☐ **OR** high blood pressure ☐ ?		
2. Do you feel pain in your chest at rest, during your daily activities of living, **OR** when you do physical activity?		
3. Do you lose balance because of dizziness **OR** have you lost consciousness in the last 12 months? Please answer **NO** if your dizziness was associated with over-breathing (including during vigorous exercises).		
4. Have you ever been diagnosed with another chronic medical condition (other than heart disease or high blood pressure)? **PLEASE LIST CONDITION(S) HERE:**_____		
5. Are you currently taking prescribed medications for a chronic medical condition? **PLEASE LIST CONDITION(S) AND MEDICATIONS HERE:**_____		
6. Do you currently have (or have had within the past 12 months) a bone, joint, or soft tissue (muscle, ligament, or tendon) problem that could be made worse by becoming more physically active? *Please answer NO if you had a problem in the past, but it does not limit your current ability to be physically active.* **PLEASE LIST CONDITION(S) HERE:**_____		
7. Has your doctor ever said that you should only do medically supervised physical activity?		

If any of the above are checked YES, the member must be given the medical clearance form and scheduled with a nurse for medical screening.

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Medical History

FOLLOW-UP QUESTIONS ABOUT YOUR MEDICAL CONDITION(S)	Yes	No
1. Do you have Arthritis, Osteoporosis, or Back Problems? If the above condition(s) is/are present, answer questions 1a-1c **If NO☐ go to question 2**		
1a. Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer **NO** if you are not currently taking medications or other treatments)		
1b. Do you have joint problems causing pain, a recent fracture or fracture caused by osteoporosis or cancer, displaced vertebra (e.g., spondylolisthesis), and/or spondylolysis/pars defect (a crack in the bony ring on the back of the spinal column)?		
1c. Have you had steroid injections or taken steroid tablets regularly for more than 3 months?		
2. Do you have Cancer of any kind? If the above condition(s) is/are present, answer questions 2a-2b **If NO☐ go to question 3**		
2a. Does your cancer diagnosis include any of the following types: lung/bronchogenic, multiple myeloma (cancer of plasma cells), head, and neck?		
2b. Are you currently receiving cancer therapy (such as chemotheraphy or radiotherapy)?		
3. Do you have a Heart or Cardiovascular Condition? *This includes Coronary Artery Disease, Heart Failure, Diagnosed Abnormality of Heart Rhythm.* If the above condition(s) is/are present, answer questions 3a-3d **If NO☐ go to question 4**		
3a. Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer **NO** if you are not currently taking medications or other treatments)		
3b. Do you have an irregular heart beat that requires medical management? (E.g., atrial brillation, premature ventricular contraction)		
3c. Do you have chronic heart failure?		
3d. Do you have diagnosed coronary artery (cardiovascular) disease and have not participated in regular physical activity in the last 2 months?		
4. Do you have High Blood Pressure? If the above condition(s) is/are present, answer questions 4a-4b **If NO☐ go to question 5**		
4a. Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer **NO** if you are not currently taking medications or other treatments)		
4b. Do you have a resting blood pressure equal to or greater than 160/90 mmHg with or without medication? (Answer **YES** if you do not know your resting blood pressure)		
5. Do you have any Metabolic Conditions? *This includes Type 1 Diabetes, Type 2 Diabetes, Pre-Diabetes.* If the above condition(s) is/are present, answer questions 5a-5e **If NO☐ go to question 6**		
5a. Do you often have difficulty controlling your blood sugar levels with foods, medications, or other physician prescribed therapies?		
5b. Do you often suffer from signs and symptoms of low blood sugar (hypoglycemia) following exercise and/or during activities of daily living? Signs of hypoglycemia may include shakiness, nervousness, unusual irritability, abnormal sweating, dizziness or light-headedness, mental confusion, difficulty speaking, weakness, or sleepiness.		
5c. Do you have any signs or symptoms of diabetes complications such as heart or vascular disease and/or complications affecting your eyes, kidneys, **OR** the sensation in your toes and feet?		
5d. Do you have other metabolic conditions (such as current pregnancy-related diabetes, chronic kidney disease, or liver problems)?		
5e. Are you planning to engage in what for you is unusually high (or vigorous) intensity exercise in the near future?		

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Medical History Continued

FOLLOW-UP QUESTIONS ABOUT YOUR MEDICAL CONDITION(S)	Yes	No
6. Do you have any Mental Health Problems or Learning Difficulties? *This includes Alzheimer's, Dementia, Depression, Anxiety Disorder, Eating Disorder, Psychotic Disorder, Intellectual Disability, Down Syndrome.* If the above condition(s) is/are present, answer questions 6a-6b **If NO☐ go to question 7**		
6a. Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer **NO** if you are not currently taking medications or other treatments)		
6b. Do you **ALSO** have back problems affecting nerves or muscles?		
7. Do you have a Respiratory Disease? *This includes Chronic Obstructive Pulmonary Disease, Asthma, Pulmonary High Blood Pressure.* If the above condition(s) is/are present, answer questions 7a-7d **If NO☐ go to question 8**		
7a. Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer **NO** if you are not currently taking medications or other treatments)		
7b. Has your doctor ever said your blood oxygen level is low at rest or during exercise and/or that you require supplemental oxygen therapy?		
7c. If asthmatic, do you currently have symptoms of chest tightness, wheezing, labored breathing, consistent cough (more than 2 days/week), or have you used your rescue medication more than twice in the last week?		
7d. Has your doctor ever said you have high blood pressure in the blood vessels of your lungs?		
8. Do you have a Spinal Cord Injury? *This includes Tetraplegia and Paraplegia.* If the above condition(s) is/are present, answer questions 8a-8c **If NO☐ go to question 9**		
8a. Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer **NO** if you are not currently taking medications or other treatments)		
8b. Do you commonly exhibit low resting blood pressure significant enough to cause dizziness, light-headedness, and/or fainting?		
8c. Has your physician indicated that you exhibit sudden bouts of high blood pressure (known as Autonomic Dysreflexia)?		
9. Have you had a Stroke? *This includes Transient Ischemic Attack (TIA) or Cerebrovascular Event.* If the above condition(s) is/are present, answer questions 9a-9c **If NO☐ go to question 10**		
9a. Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer **NO** if you are not currently taking medications or other treatments)		
9b. Do you have any impairment in walking or mobility?		
9c. Have you experienced a stroke or impairment in nerves or muscles in the past 6 months?		
10. Do you have any other medical condition not listed above or do you have two or more medical conditions? If the above condition(s) is/are present, answer questions 10a-10c **If NO☐ go to page 4**		
10a. Have you experienced a blackout, fainted, or lost consciousness as a result of a head injury within the last 12 months OR have you had a diagnosed concussion within the last 12 months?		
10b. Do you have a medical condition that is not listed (such as epilepsy, neurological conditions, kidney problems)?		
10c. Do you currently live with two or more medical conditions?		

Please list your medical condition(s): _____

and any related medications here: _____

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Medical History Continued

List current medications (prescriptions and over-the-counter). If none, write "none."

Medication	Dose	X a Day	Reason

Medication Allergies: _____

STAFF USE ONLY

☐ Requested medical clearance.
Date: ____ / ____ / ____
Reason: _____ Initials: _____

☐ Medical Clearance is not required at this time. The member is between the ages of 18 and 59 years old, and stated they have no illnesses or medical conditions.
Date: ____ / ____ / ____ Initials: _____

☐ Member cleared to exercise – received medical clearance with no restrictions.
Date Clearance Received: ____ / ____ / ____ Initials: _____

☐ Cleared to exercise with restriction of: _____
Date Clearance Received: ____ / ____ / ____ Initials: _____

☐ Not cleared to exercise at this time.
Date Clearance Received: ____ / ____ / ____
Explain: _____
Date Member Notified: _____ Time: _____ Initials: _____

☐ Member declined medical clearance.

Notes: _____

Nurse/Trainer: All documentation must be dated and signed

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STAFF USE ONLY

Notes:

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Physicians

To The Physician:

Your patient has become a member of CentraState Fitness & Wellness Center. It is our goal to provide them with a safe and assisted environment to exercise as they work towards optimal health. They can receive screening and fitness assessments from the nursing department and one-to-one programming from the exercise physiologist/personal trainer on a regular basis as part of their membership.

As a facility, we recommend medical clearance for any individual who is 50 years and older, under 18 years old, or for any individual with a medical history or condition. The goal of the medical clearance is to outline any restrictions or guidelines for your patient that may be needed to keep them safe while exercising. As each individual is unique and may require specific guidelines/restrictions, we are asking you for your input in establishing what may be needed for your patient.

Once we receive the medical clearance, the exercise physiologists/personal trainers utilize the guidelines listed on the clearance form as they program each individual. Receipt of the completed medical clearance form is required before the trainers will program your patient to ensure they comply with any noted medical concerns. We also encourage you, as the Physician, to list any activity/area of need that you think would benefit your patient. If you would like to communicate with an exercise physiologist/personal trainer, please indicate your telephone number or e-mail address on the clearance form so they may contact you.

In compliance with HIPAA regulations, we do not require you to list your patient's history or condition. (We will be obtaining medical histories directly from the member during the nursing assessment.) Also, please note that the fax number listed on the top of the form is a direct line to the Nursing Office. All information will be safeguarded in accordance with standard medical-legal protocol. The clearance form will be put directly into the member's file. It is important that you delineate one of the three noted options. If no restrictions or guidelines are needed, please mark the "no restriction" box. Please identify any restrictions or guidelines that may be needed to keep your patient safe. If you have any questions or concerns about the Medical Clearance Form please contact the Nursing Department at 732.845.9400. We appreciate your assistance and input.

Nursing Department
CentraState Fitness & Wellness Center
p: 732.845.9400 f: 732.845.9060
901 W. Main Street | Freehold, NJ 07728
centrastatetness.com

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PHYSICIAN STATEMENT AND CLEARANCE FORM

Dear Doctor _____:

We are pleased to inform you that your patient _____ has decided to participate in the CentraState Fitness & Wellness Center exercise program. We ask that you kindly complete the form and **RETURN IT TO YOUR PATIENT OR FAX TO: 732.845.9060 AT YOUR EARLIEST CONVENIENCE.**

Our member's safety is our primary concern. For that reason, we ask that medical clearance be obtained for anyone 50 years of age and older, under 18 years of age, and anyone with a history of, or currently being treated for, any disease, condition, illness, or injury that may impair your patient's ability to exercise.

When your patient receives this release it will enable them to begin their exercise program without delay. We thank you for your input. If you have any questions concerning our program, please do not hesitate to call our Nursing or Fitness Department.

☐ I concur with my patient's participation with no restrictions.

☐ I concur with my patient's participation with the following restrictions:

_____

_____

_____

☐ I do not concur with my patient's participation in a supervised exercise program. (If checked your patient will not be allowed to participate in our fitness program until cleared by a physician.)

Reason _____

PHYSICIAN'S NAME (PRINT) _____

PHYSICIAN'S SIGNATURE _____

Date ____ /____ /____

I hereby give my permission to release any pertinent information from any medical records to the staff of CentraState Fitness & Wellness Center.

Member/Patient Name _____ Phone: _____

Member/Patient Signature _____ DOB: _____

Date ____ /____ /____