



F.I.T. Medical History

Personal Information

Name: _____ Age: _____ Birthdate: _____ Sex: _____

Home Address: _____ Phone: _____

_____ Alt. Phone: _____

Last day of physical therapy: _____ Diagnosis: _____

Primary Therapist: _____

Emergency Information

Personal Physician: _____ Phone: _____

Referring Physician: _____ Phone: _____

Do you have medical alert identification? _____ If yes, where is it located? _____

List any allergies: _____

Person to be notified in case of emergency: _____

Relationship to you: _____ Phone: _____

Work Phone: _____ Pager/Cell: _____

Current Medications: _____

Have you been hospitalized in the past 6 months? Yes No If yes, why? _____

Personal Medical History

Please check the following diseases or conditions that you currently have:

<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	High Cholesterol	<input type="checkbox"/>	Angina Pain	<input type="checkbox"/>	Heart Attack
<input type="checkbox"/>	Heart Surgery	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	Arteriosclerosis	<input type="checkbox"/>	Aneurysm
<input type="checkbox"/>	Anemia	<input type="checkbox"/>	Infectious Mononucleosis	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	Gout	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Pneumonia	<input type="checkbox"/>	Bronchitis
<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	Thyroid Problems	<input type="checkbox"/>	Hernia	<input type="checkbox"/>	Cancer
<input type="checkbox"/>	Epilepsy or Seizures	<input type="checkbox"/> Other:					

Have you experienced any of the following on a recurring basis?

	At rest: YES	During exertion: YES
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness or fainting	<input type="checkbox"/>	<input type="checkbox"/>
Daily coughing	<input type="checkbox"/>	<input type="checkbox"/>
Chest pressure	<input type="checkbox"/>	<input type="checkbox"/>
Chest pain	<input type="checkbox"/>	<input type="checkbox"/>
Joint soreness	<input type="checkbox"/>	<input type="checkbox"/>
Joint swelling	<input type="checkbox"/>	<input type="checkbox"/>
Skipped heart beats	<input type="checkbox"/>	<input type="checkbox"/>
Fast heart rate	<input type="checkbox"/>	<input type="checkbox"/>
Sudden numbness or tingling	<input type="checkbox"/>	<input type="checkbox"/>
Blurring vision	<input type="checkbox"/>	<input type="checkbox"/>
Please explain any checked categories above:		

Do you smoke: Yes No

Exercise/Recreational History

Please list any physical and recreational activities in which you participate that entail sustained physical exertion (walking, running, lifting, carrying, etc) _____

Do you have any physician ordered restrictions on your activity level?: _____

Goals for exercise (weight management, stress management, general fitness, etc): _____



PROVIDENCE

Individual Exercise Program – Release of Liability

I, _____, the undersigned agree and understand that:
(Please print full name)

1. Weight training, aerobic exercise, and other cardiovascular exercise may be hazardous and result in injury to myself or other members; and
2. Other aspects of weight training, aerobic exercise and cardiovascular exercise may result in injury to me or other members.

I assume all risks of injury incurred or suffered while on the premises of Providence Hospital – Center for Rehabilitation and Fitness. Moreover, I release and agree not to sue if agents, servants, associations, employees, or anyone connected with Providence Hospital.

Providence Park Rehab has agreed to allow the undersigned to utilize the facility's exercise equipment during operational hours, Monday through Friday, unless otherwise indicated, to continue his/her fitness program.

I understand that I am no longer under the direct care of a Physical Therapist and have been formally discharged from Physical Therapy. The F.I.T. Program is designed to be a medically supervised **INDEPENDENT** service.

I understand that if **any point** during my FIT program membership that I have a change in my medical status, that I **must** notify the Rehab Front Desk 248/465-4191 and have a **clearance for continuing with physical exercise** from my physician.

I understand the fees are as follows:

1 month membership (exercise only)	\$ 40.00
Exercise Progression Visit	\$30.00

I, the undersigned member, acknowledge that I have read and understand the above contract and enter into it voluntarily.

Additional terms: Providence Park Rehab shall not be responsible for the loss of member's personal property, either by reason of theft or loss from the premises.

This contract cannot be canceled or rescinded, nor shall the membership fee be refunded, except on terms and within the sole discretion of Providence Hospital, nor shall any membership be transferable to another person, or persons.

Participant's Signature

Date