

First Name	Last Name	Male	Female
<hr/>			
Home Address			
<hr/>			
City	State	Zip	
<hr/>			
Phone	Birthdate	Age	
<hr/>			
Email			
<hr/>			
Membership Information Requested?	YES	NO	

Health and Fitness Goals Please select all that apply

- | | | |
|--------------------------|-----------------------------|--------------------------------|
| Weight Loss | Increase Flexibility | Improve Muscle Tone |
| Lower Cholesterol | Lower Blood Pressure | Sport Specific Training |
| Other <hr/> | | |

How did you hear about us? Please select all that apply

- | | | | | |
|-------------------------|----------------|-----------------|---------------|----------------------|
| Member Referral | Website | Hospital | Doctor | Work |
| Physical Therapy | Mailing | Cardiac | Rehab | Word of Mouth |
| Other <hr/> | | | | |

Which of our members referred you to us? **First Name** **Last Name**

GUEST WAIVER

Before I exercise or participate in a program at LifeStyles I understand that it is my responsibility to notify personnel of any adverse or unusual signs/symptoms I may experience during exercise. I agree that the LifeStyles officers or any agents will not be liable to me or anyone else on account of adverse consequences resulting from my exercise on the equipment or participating in the classes at this facility.

Guest Signature **Date**

Guest Parent or Guardian Signature (17 and under) **Date**

Questions

YES	NO	Has your doctor ever said that you have a heart condition and that you should only do physical activity recommended by a doctor?
YES	NO	Do you feel pain in your chest when you do physical activity?
YES	NO	In the past month, have you had chest pain when you were not doing any physical activity?
YES	NO	Do you lose your balance because of dizziness, or do you ever lose consciousness?
YES	NO	Do you have a bone or joint problem (for example, back, knee, or hip) that could be made worse by a change in your physical activity?
YES	NO	Is your doctor currently prescribing drugs (for example, water pills) for your blood pressure or heart condition?
YES	NO	Do you know of any other reason why you should not do physical activity?

INFORMED CONSENT FOR EXERCISE PARTICIPATION

I desire to engage voluntarily in the LifeStyles exercise program. I understand that the activities are designed to place a gradually increasing workload on the cardiorespiratory system and to thereby attempt to improve its function. The reaction of the cardiorespiratory system to such activities can't be predicted with complete accuracy. There is a risk of certain changes that might occur during or following the exercise. These changes might include abnormalities of blood pressure or heart rate.

I understand that the purpose of the exercise program is to develop and maintain cardiorespiratory fitness, body composition, flexibility, and muscular strength and endurance. Specific exercise programs are available based on my needs, interests and if necessary my doctors recommendations. All exercise programs include warm-up, exercise at target heart rate, and cool down. The programs may involve walking, jogging, swimming, cycling, participation in exercise fitness, rhythmic aerobic exercise, choreographed fitness classes, calisthenics or strength straining. All programs are designed to place a gradually increasing workload on the body in order to improve overall fitness. The rate of progression is regulated by exercise target heart rate and perceived effort of exercise.

I understand that I am responsible for monitoring my own condition throughout the exercise program and should any unusual symptoms occur, I will cease my participation and inform the instructor of the symptoms. By signing this consent form, I affirm that I have read this form in its entirety and that understand the nature of an exercise program. I also agree that my questions regarding an exercise program have been answered to my satisfaction.

In the event that a medical clearance form must be obtained prior to my exercise participation in an exercise program, agree to consult my physician and obtain written permission from my physician or sign an assumption of risk form prior to the commencement of any exercise program.

Also, in the consideration for being allowed to participate in an exercise program at LifeStyles, I agree to assume the risk of such exercise, and further agree to hold harmless the Center and its staff members conducting the exercise program from any and all claims, such losses, or related causes of action for damages, including but not limited to such claims that may result from injury or death, accidental or otherwise, during, or arising in any way from the exercise program.

First Name

Last Name

Signature

Date

Guest Parent or Guardian Signature (17 and under)

Date

Witness Signature

Date

NOTE: This physical activity clearance is valid for the current calendar year ending December 31 and becomes invalid if your condition changes so that you would answer YES to any of the above seven questions.