WATAUGA MEDICAL CENTER
Member of Appalachian Regional Healthcare System

Check Off Sheet

Please Check When Complete:

☐ Name: _____ Phone number:_____
Please circle class preference:

Class A:	Monday, Wednesday and Friday	11:00 a.m. - 12:00 p.m.
Class B:	Tuesday and Thursday	11:00 a.m. - 12:00 p.m.
Class C:	Monday, Wednesday and Friday	3:00 p.m. - 4:00 p.m.
Class D:	Tuesday and Thursday	1:00 p.m. - 2:00 p.m.
Class E:	Tuesday and Thursday	3:00 p.m. - 4:00 p.m.
Class F:	Tuesday and Thursday	10:00 a.m. - 11:00 a.m.

☐ Application

☐ Index Card with Emergency Contact and Prescriptions

☐ Release

☐ Medical Screening Questionnaire

☐ Physician Referral if needed

☐ Cost:

2 Days a Week $30.00

3 Days a Week $45.00

Payment Amount: $_____
Date Received: _____

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Application

COMPLETE ALL SECTIONS - PLEASE PRINT

1. First_____ M.I._____ Last Name_____

Sex (M/F)_____ Birthdate:_____/ _____/ _____ Email: _____

Date: _____ Registration: _____

2. Mailing Address _____ Apt. # _____

City _____ State _____ Zip _____

3. Phone # Home ( ) _____ Business ( ) _____

4. Emergency Contact (Local) _____

Home Phone # _____ Business/Cell Phone _____

5. Do you have arthritis? ☐ YES ☐ NO
If yes, what type? _____

6. How did you find out about the Arthritis Aquatic Program held here at the Wellness Center? _____

7. I would prefer to attend the (please check)

☐ Class A	Monday, Wednesday and Friday	11:00 a.m. - 12:00 p.m.
☐ Class B	Tuesday and Thursday	11:00 a.m. - 12:00 p.m.
☐ Class C	Monday, Wednesday and Friday	3:00 p.m. - 4:00 p.m.
☐ Class D	Tuesday and Thursday	12:00 p.m. - 1:00 p.m.
☐ Class E	Tuesday and Thursday	3:00 p.m. - 4:00 p.m.
☐ Class F	Tuesday and Thursday	10:00 a.m. - 11:00 a.m.

8. My current activity level (check only one)
☐ I have a lot of joint limitations or many joints affected by arthritis and I am not very physically active.
☐ I only have minor joint problems but have weak muscles or get tired easily. I have been doing some exercise or physical activity

9. Physician (Local) : _____
Physician's Phone #:_____

10. Do you walk with any assistive devices? _____

11. Are you a member of the Wellness Center?
☐ Yes ☐ No

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Medical Questionnaire

Name:_____Date of Birth:_____

Resting Blood Pressure _____ Weight: _____ Height: _____ Date of Physical: _____

CATEGORY ONE	**YES**	**NO**	**CATEGORY THREE (cont.)**	**YES**	**NO**
A. Are you age 40 or older?	☐	☐	Has a Physician ever told you that you have/had:	☐	☐
B. Do you smoke 10 or more cigarettes a day?	☐	☐	G. Cardiovascular disease (heart disease, stroke) or peripheral vascular disease?	☐	☐
CATEGORY TWO	☐	☐	H. Diabetes?	☐	☐
A. Do you have a family history of cardiovascular disease prior to age 55 in parents or siblings?	☐	☐	I. Pulmonary Disease?	☐	☐
B. Has a physician ever told you that you have high cholesterol (>240)?	☐	☐	J. Metabolic Disease (liver, thyroid, kidney)?	☐	☐
CATEGORY THREE	☐	☐	K. Heart attack?	☐	☐
A. Are you pregnant?	☐	☐	M. Have you ever had orthopedic surgery?	☐	☐
B. Do you experience dizziness?	☐	☐	N. Have you had surgery in the past year?	☐	☐
C. Do you experience skipped heart beats or a very rapid resting heart rate?	☐	☐	O. Are you currently under the care of a physician for a medical condition?	☐	☐
D. Do you experience ankle swelling?	☐	☐	P. Do you have an orthopedic problem?	☐	☐
E. Do you experience discomfort breathing while lying down or wake up suddenly gasping for air?	☐	☐	Q. Do you have any paralysis or current neuromuscular involvement due to multiple sclerosis, stroke, or other condition?	☐	☐
F. Do you-experience chest pain?	☐	☐		☐	☐

KEY: Each "yes" answer in category one = **1 point,** category two = **2 points**, category three= **3 points.** Three or more total points requires a physician's referral prior to your participation in the Arthritis Aquatic Program. Please explain all "yes" answers except those in Category One, and any other permanent medical information in the space below. Please list any medications

_____

_____

I certify that all answers and statements listed I this Application and Medical Screening Questionnaire are my own and are true to the best of my knowledge. I understand that misinformation or false statements may result in revocation of this application or membership resulting there from. I understand that scoring 3 or more points on the Wellness Medical Screening Questionnaire requires a physician recommendation for membership and participation in Arthritis Aquatic Program held at the Paul H. Broyhill Wellness Center.

Signature of Applicant: _____ Date: _____

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Participant Release Form

Arthritis Aquatic Program

I understand and agree that there are risks, foreseeable and unpredictable, associated with any exercise program. I am aware of these risks and agree that my participation is at my own risk. I hereby agree that neither Appalachian Regional Health System not the Paul H. Broyhill Wellness Center, nor their respective chapters, officers, directors, employees, agents, members or volunteers, shall assume or have any responsibility or liability for expenses, medical treatment or compensation for any injury I may suffer during or resulting from my participation in the Arthritis Aquatic Program. I do hereby, for myself, my heirs, executors and administrators, waive, release, and forever discharge any and all rights and claims for damages that I may have or that may hereafter accrue to me arising out of or in any way connected with my participation in this program.

I also represent and warrant that I have been advised to seek consultation from my doctor about whether I can safely participate in this program and whether there are precautions or limitations to my participation.

I will update my medical history and list of medication as changes occur.

Participant Signature: _____ Date: _____