WATAUGA MEDICAL CENTER
Member of Appalachian Regional Healthcare System
PAUL H. BROYHILL WELLNESS CENTER
232 Boone Heights Drive • Boone, NC 28607
(828) 266-1060

Membership Application

Last Name	First Name	Middle Initial	Email Address
Mailing Address		City	State Zip
Home Phone	Work Phone	Cell Phone	Sex:
Birthdate:			
Emergency Contact:		Phone: ☐Home ☐Work ☐Cell	Phone: ☐Home ☐Work ☐Cell

If joining as a family, please list the related member below:

Name	Birthdate:	Name	Birthdate:

How did you hear about the Wellness Center? ☐Newspaper ☐Radio ☐Internet ☐Group Presentation
☐Physician _____ ☐Employee _____ ☐Member _____
☐Other _____

What activities are you interested in?

☐Aerobic Classes	☐Aerobic Equipment	☐Basketball	☐Weight Training
☐Nutrition Analysis	☐Walking / Jogging	☐Racquetball	☐Weight Management
☐Rehabilitation Therapy	☐Child Care Services	☐Swimming	☐Stress Management
☐Massage Therapy	☐Cooking Classes	☐Other:	

What is your fitness goal? _____

For Office Use Only	Account #	
Joining Date:	Expiration Date:	Membership Type:
Initiation Fee:	Membership Fee:	Payment Option:
Company Name (If corporate)		Corporate Account#

Medical Screening Questionnaire

Comments:

Name _____

Date of Birth _____

Resting Blood Pressure _____

Weight _____ Height _____

Physician _____

Date of Physical _____

Key:

Each "yes" answer in...

Category 1 = 1 point
Category 2 = 2 points
Category 3 = 3 points

Three or more total points requires a physician's referral to your fitness assessment, fitness instruction and personal training.

Please explain all "yes" answers in Category 2 and Category 3, as well as any other pertinent medical information and medications in the space below.

Category 1	Yes	No	Points
1. Are you age 40 or older?			
2. Do you smoke 10 or more cigarettes a day?			
Category 2			
1. Do you have a family history of cardiovascular disease prior to age 55 in parents or siblings?			
2. Has a physician ever told you that you have high cholesterol (>240)?			
Category 2 - Total Points			
Category 3			
Has a physician ever told you that you have/had:			
Cardiovascular Disease (heart disease, stroke) or peripheral vascular disease?			
Diabetes?			
Pulmonary Disease?			
Metabolic Disease (liver, thyroid, kidney)?			
Heart attack?			
Have you every had orthopedic surgery?			
Have you had surgery in the past year?			
Are you currently under the care of a physician for a medical condition?			
Do you have an orthopedic problem?			
Do you have any paralysis or current neuromuscular involvement due to multiple sclerosis, stroke or other condition?			
Category 3 - Total Points			

I certify that all answers and statements listed in 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. I understand that scoring 3 or more points on the Medical Screening Questionnaire requires a physician recommendation for membership and may exclude me from sub maximal bike testing.

Signature of Applicant: _____ Date: _____

Parent/Guardian Signature (if under 18): _____ Date: _____

Informed Consent and Release

This testing and evaluation program provides information on your present level of health and fitness and aids in the development of an individual exercise prescription. The fitness assessment emphasizes cardiovascular and muscular fitness utilizing the following evaluations:

- Medical History
- Body Composition
- Muscular Strength and Endurance
- Functional Capacity
- Flexibility

In completing the fitness assessment, there exists the possibility of abnormal responses to exercise. These responses include, but are not limited to, the following: abnormal heart rhythms, fainting, dizziness, abnormal blood pressure response, fatigue or in rare instances, cardiac arrest. Every effort will be made to minimize the possibility of the potential risks occurring.

I hereby expressly release Watauga Medical Center, the Paul Broyhill Wellness Center and it's employees from all responsibilities for liabilities to me for injuries that might be sustained while doing any exercise, or utilizing any of the facilities and equipment at the Wellness Center. I also expressly acknowledge that any and all fitness testing undergone prior to utilization of said facilities was done merely for informational purposes of my fitness program at the Wellness Center and that said testing and results therefore in no way declare my fitness or lack thereof for utilization of the Wellness Center.

If you have any questions regarding the assessment, we urge you to consult with our staff.

Member signature: _____ Date: _____

Staff signature: _____ Date: _____

Confidentiality Statement

All fitness evaluation data, physician referral and membership information collected by the Wellness Center staff is treated as confidential material. The sole purpose of collecting this material is to design a safe, effective exercise prescription geared to the individual needs of the participant. This information will not be released from the participant's file without the written consent of the participant.

Member Name:	**Date:**
Medical Considerations:	
Membership type:	
☐ Individual	☐ Couple - Spouse #
☐ Silver	☐ Silver Couple - Spouse #
☐ 2nd Member - Spouse #	☐ Child - Parent #
☐ Corporate 1	☐ Employee - ARHS / BRH / CMH / WMC / ARMA
☐ Corporate 2	☐ Employee Couple - ARHS / BRH / CMH / WMC / ARMA
☐ Corporate 3	☐ Wellness Center Staff

Member Protocol *(Enter date and initials after each is completed)*	
_____ Received Medical History	_____ Medical History signed
_____ Informed consent signed	_____ Received membership information sheet
_____ Membership agreement signed	_____ Gave referral for physician's office
_____ Membership card given	_____ Referral returned, physician's clearance given
_____ Freeze/cancel and card policies given	_____ Declined medical referral
_____ 11-13 year old guidelines signed	_____ Child care rules & regulations given
_____ Scheduled fitness assessment/fitness instruction	_____ KI entry complete _____ billing established _____ emergency contact

***If you lose your card, there is a ten dollar fee to replace it, which covers the cost of the new card and the new paperwork involved in changing the member number.*

Fitness Assessment

Member name: _____ ☐ Male ☐ Female Physician: _____

Date: _____ Age: _____ Staff Member Name: _____

Resting Blood Pressure:	Resting Heart Rate:	Height (inches):	Weight (lbs.):
Body Composition data:		Body Circumference:	
Site #1		Thigh	
Site #2		Chest	
Site #3		Arm	
Sum of 3 Sites		Waist	
Percent Body Fat		Hips	
Fat Weight (lbs.)		Calf	
Lean Weight (lbs.)			
Target Weight (lbs.)			

Cardiovascular *(see reverse side of form)*

Flexibility Data

Sit & Reach	*1st try*	*2nd try*	*3rd try*	Best Effort =

Grip Strength

R	*1st try*	*2nd try*	*3rd try*
L	*1st try*	*2nd try*	*3rd try*

Curl-Ups:	Push-ups:	Comments:

Bicycle Ergometer Test _____% of Predicted MAX HR = _____ bpm

Resting Heart Rate_____ bpm Resting Blood Pressure _____ mmHg

RPE	BP	HR	KP	Workload (KGM)	Watts
		/ /	0.5	150	25
		/ /	1.0	300	50
		/ /	1.5	450	75
		/ /	2.0	600	100
		/ /	2.5	750	125
		/ /	3.0	900	150
		/ /	3.5	1050	175
		/ /	4.0	1200	200
			Recovery (150 KGM)		
Comments/Reason for Stopping:					
Medications:					
Limitations:					