CHI St. Joseph Health
Imagine better health.℠

WellFIT Registration Form & Health History

1600 Joseph Dr.
Bryan, TX 77802
P (979)731-6131

Personal Information

First Name		Last Name	
Address	City		Zip Code
Date of Birth	Gender: M F	Phone Number	Email
Emergency Contact Name:		Emergency Contact Number:	
Insurance Based? YES NO		Member ID Number:	
Are you a MatureWell Lifestyle Club Member? YES NO			
How did you hear about us? Flyer Friend/Family Physician Online TV Newspaper Other: _____			

** Members must be at least 18 years old to participate in the WellFIT Program

Membership– Please check preferred membership type. Discounted rates will be applied once all paperwork has been received.

✓	Type of Membership	Price
☐	Individual	$40
☐	Individual + One	$70
☐	Club Rate *	$35
☐	Insurance Based	$0

Office Use Only:
Key Tag Number:

Staff Initials:

*Club Rate discounts for families, MatureWell Lifestyle Club members, BISD, City of Bryan, CSISD, City of College Station, TAMU employees & Joint University. Discounted rates cannot be combined.
*Lost Key Tag fee is $5.00
Prices as of 03/20/2017; subject to change.

ACKNOWLEDGEMENT OF DUES LIABILITY

I hereby acknowledge that my membership in the CHI St. Joseph Health WellFIT Program is monthly & payments are due by the 1st of each month. I understand that **written cancellation or 2 month hold is required by the 7th of the month. Until written cancellation is received, I will be billed for that month, and every month thereafter. NO PHONE CANCELLATIONS WILL BE ACCEPTED. Closing for the Holidays, acts of God, and mechanical failures are not refunded.**

X _____

Signature **Date**

INFORMED CONSENT

By signing this document, I acknowledge that I have voluntarily chosen to participate in a program of progressive physical exercise. I acknowledge being informed of the strenuous nature of the program and the potential for unusual, but possible, physiological results including but not limited to abnormal blood pressure, fainting, heart attack or death. I assume all risk for my health and well-being and hold harmless of any responsibility to the instructor, facility or any persons involved with this program and testing procedures. I understand that questions about exercise procedures and recommendations are encouraged and welcomed.

X _____

Signature **Date**

WAIVER

By signing this document, I acknowledge that I have been informed of the need to obtain a physician's examination and approval prior to beginning this exercise program. I fully understand that the program may be strenuous and choose to participate completely voluntarily. I accept all responsibility for my health and any resultant injury or mishap that may affect my well-being or health in any way. I hold harmless of any responsibility to the instructor, facility or any persons involved with this program or testing procedures.

X _____

Signature **Date**

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AUTOMATIC CREDIT CARD PAYMENT AUTHORIZATION

☐ No, I do not wish to set up an automatic payment for my WellFIT Program membership at this time.
☐ Yes, I authorize use of the below credit card to automatically pay my monthly WellFIT Program dues.

Name: _____ Zip Code: _____
(As it appears on credit card)

Card Number: ☐☐☐☐ - ☐☐☐☐ - ☐☐☐☐ - ☐☐☐☐

Card Type: ☐ Visa ☐ MasterCard ☐ Discover ☐ American Express

Expiration date: ☐☐ / ☐☐

I understand that I am in full control of my payment and that if, at any time, I decide to discontinue this form of payment, I will notify CHI St. Joseph Health WellFIT Program in writing before the end of the month. I also understand that if I decide to change my level of membership, I must complete another authorization form.

X_____

Signature **Date**

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HEALTH HISTORY QUESTIONAIRE

All questions contained in this questionnaire are strictly confidential
and will become part of your membership record.

Name *(Last, First, M.I.):*	☐ M ☐ F	DOB:
Physician:	Date of last physical exam:	

PERSONAL HEALTH HISTORY

On most days, how many hours per day do you spend sitting while at home and/or during leisure time. This may include time spent visiting friends, reading or watching television?

☐ Less than 1 hour ☐ 1 hour ☐ 2 hours ☐ 3 hours ☐ 4 hours or more

How many days are you physically active for at least 30 minutes per day? Add up all the time you spent in any kind of activity that increased your heart rate and made you breathe hard some of the time.

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7

Where are you most physically active? (Check all that apply)

☐ Parks/Trails ☐ Home Fitness Center ☐ School Track ☐ Work Site/Office Place
☐ Local Gyms or Fitness Centers ☐ Local Mall ☐ Neighborhood

Why do you want to participate in our WellFIT Program? (Check all that apply)

☐ Convenience ☐ Price ☐ Location
☐ Family Member attends Cardiac Rehab ☐ Friend Referral ☐ Free Membership through Special Program

Exercise	☐ Sedentary (No exercise)
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)

PLEASE CHECK YOU CURRENT OR PAST MEDICAL HISTORY:

☐ ANEMIA	☐ EPILEPSY/SEIZURES	☐ PACEMAKER
☐ ANGINA/CHEST PAIN	☐ EMOTIONAL/PSYCHOLOGICAL	☐ PREGNANT NOW
☐ ARTHRITIS	☐ HEADACHE/MIGRAINE	☐ SLEEP DIFFICULTY
☐ ASTHMA	☐ HEAD INJURY	☐ SMOKING: ___ PACKS PER DAY
☐ BACK INJURY	☐ HEARING LOSS	☐ STROKE/ TIA
☐ BALANCE/ FALL RISK	☐ HEART ATTACK/CIRCULATORY	☐ SURGERY: _____
☐ BLOOD CLOT/EMBOLISM	☐ HERNIA	☐ OTHER: _____
☐ BOWEL/BLADDER PROBLEM	☐ HIGH BLOOD PRESSURE	**RECENT CHANGES IN:**
☐ BRONCHITIS/EMPHYSEMA	☐ INFECTIOUS DISEASE	☐ Weight
☐ CANCER: _____	☐ NECK INJURY	☐ Energy level
☐ DIABETES	☐ NUMBNESS/TINGLING	☐ Ability to sleep
☐ DIZZINESS/FAINTING	☐ OSTEOPOROSIS	☐ Other pain/discomfort:

Member Signature: _____ Date: _____