MEMBERSHIP FORM

Name:_____

Address:_____

_____

Phone (best number to be reached):_____ Email:_____

Height:_____ Weight: _____ Age:_____

Personal Physician:_____

Payment Authorization: Acceptable forms of payment include cash or check. **Fee** for returned check is $50.00

MEMBERSHIP Rate:_____ ***MEMBERSHIP Length:_____***

Initial your acceptance of the membership rate here: _____

This PAR-Q Section gathers relevant information about your health that will assist in determining the level of appropriateness as related to participating in a wellness program. Please answer all questions to the best of your knowledge.
ALL HEALTH INFORMATION IS KEPT STRICTLY CONFIDENTIAL TO COMPLY WITH APPLICABLE STATE AND FEDERAL PRIVACY LAWS AND IS NOT SHARED.

Please circle **YES** or **NO**:
1. Has your doctor ever said that you had heart trouble, heart palpitation, or coronary disease?
YES NO
2. Do you frequently suffer from pains in your heart/chest upon exertion or when at rest?
YES NO
3. Do you often feel faint or have spells of severe dizziness?
YES NO
4. Do you have high blood pressure (hypertension)?
YES NO
5. Do you have bone, joint, or back problems that have been aggravated by exercise or might be made worse with exercise?
YES NO

6. Do you smoke?
YES NO If YES, how many cigarettes per day?_____
7. Do you have diabetes?
YES NO
8. Do you have high cholesterol?
YES NO
9. Are you currently taking medication?
YES NO If YES, please name the medication and the condition for which it is being taken:
_____
_____
_____
_____
10. If female, are you pregnant?
YES NO
11. Are you over age 65 and not accustomed to vigorous exercise?
YES NO
12. Do you have a family history of heart disease? (Family history defined as having a father or brother younger than 55 or a mother or sister younger than 65 with heart disease)
YES NO
13. Is there a good reason as related to physical, mental, or emotional status not mentioned here as to why you should not begin or participate in an activity / fitness program?
YES NO

General. This agreement represents the complete understanding between you and Keystone Wellness. No representations, written or oral, other than those contained in this agreement are authorized or binding. You understand that you are obligated to pay your monthly membership fee as per the terms regardless of whether you use the facility. At the end of the term, the agreement shall continue in effect on a month-to-month basis unless new rates have become effective or you provide notice of cancellation to terminate this contract.

By signing below, member certifies that he or she is in good physical health and is able to engage in this unsupervised, voluntary program. He or she understands that Keystone Wellness urges physician approval before starting this or any activity program.

_____

PRINTED NAME OF MEMBER

_____

SIGNATURE OF MEMBER

_____

DATE