HEALTHY LIFESTYLES FITNESS CENTER
The Fitness Solution for Adults 55+!

Healthy Lifestyles Fitness Center
Membership Information

A. Identification

Name: _____
Last Name First Name M.I.

Date of Birth: _____ Current Age: _____ Gender: ☐ M ☐ F

B. General Information

Registration Date: _____

Marital Status: ☐ M-Married ☐ W-Widowed ☐ D-Divorced ☐ S-Separated ☐ N-Single

Race: ☐ 01-African American ☐ 02-Hawaiian/Pacific Islander ☐ 03-American Indian/Alaskan ☐ 04-Asian
☐ 05-White ☐ 06-Missing ☐ 07-Other ☐ 08-2 or more

Ethnicity: ☐ 01-Non-Hispanic ☐ 02 Hispanic ☐ 03 Missing

Number of people living in the household: _____

Voter Code: ☐ 01-Yes ☐ 02- No ☐ 03-Already Registered ☐ 04- Took Form Home ☐ 05- Declined

Wants to be on Newsletter Mailing List? ☐ Y ☐ N

Physician's Name and TelephoneNumber _____

C. Address Information

Address: _____ County: _____

Address: _____ Home/Cell Phone: (___) _____

City: _____ Email: _____

State: _____ Zip: _____ May we contact you by email? Y ☐ N ☐

IN CASE OF EMERGENCY, NOTIFY:

Name: _____ Relationship: _____

Address: _____

City: _____ State: _____ Zip: _____

Home/Cell Phone: (___) _____ Work Phone: (___) _____

How did you hear about us? _____

D. Health Information

1. Do you currently suffer from heart disease, stroke, diabetes, high blood pressure or high cholesterol?
If yes, please indicate which one(s) and when first diagnosed_____
_____

2. Check if you have a family history of any of the following:
☐ Heart Disease ☐ Stroke ☐ Diabetes ☐ High Blood Pressure ☐ High Cholesterol

3. Have any relatives died suddenly of heart disease without prior warning or knowledge?

☐ Yes ☐ No If yes, who was it?_____

4. List any relevant surgeries:

Procedure Name	Date

5. List any recent injuries: _____

6. List current medications:

Name of Medication	Purpose

Smoking History:

Do you smoke? ☐ Yes ☐ No

How much did/do you smoke a day? _____
How long have you been smoking? _____If quit, when? _____

Exercise History

Do you presently engage in physical activity? ☐ Yes ☐ No
What kind? _____
How hard? ☐ Light ☐ Medium ☐ Hard How often? _____
Is your occupation: ☐ Sedentary ☐ Active ☐ Heavy
Do you have discomfort, shortness of breath or pain with exercise? ☐ Yes ☐ No
If yes, with what type of exercise? _____

Stress:

Do you consider your day stressful? ☐ Yes ☐ No
What is the nature of your stress? _____
How many hours do you sleep per night? _____ Is your sleep sound? ☐ Yes ☐ No

Cancer:

Have you ever been diagnosed with cancer? ☐ Yes ☐ No
When were you first diagnosed with cancer? _____ What type of cancer? _____
Did you undergo surgery? ☐ Yes ☐ No If yes, what type and when? _____
_____
Did you undergo a node dissection? ☐ Yes ☐ No If yes, where? _____
Did you, or are you currently undergoing chemotherapy? ☐ Yes ☐ No If yes, when did you begin your treatment and when did/will it end? _____
Did you, or are you currently undergoing radiation therapy? ☐ Yes ☐ No If yes, when did you begin your treatment and when will it end? _____
Did you undergo a bone marrow transplant? ☐ Yes ☐ No If yes, when? _____
Have you undergone, or are you currently undergoing hormonal therapy? ☐ Yes ☐ No
If yes, what type? _____
Have you experienced any side effects from any of the treatments you have undergone?
☐ Yes ☐ No If yes, please describe: _____
_____
Have you worked with a physical therapist since your surgery? ☐ Yes ☐ No
If yes, when did you begin and end your therapy? _____
What is the name, address and telephone number of your physical therapist? _____
_____
Have you been diagnosed with lymphedema? ☐ Yes ☐ No
If yes, where? _____

Referred to Living Well Programs: ☐ Chronic Disease ☐ Chronic Pain ☐ Diabetes

Healthy Lifestyles Fitness Center
Waiver and Release Form

In consideration of being permitted to participate in the following service, sponsored by the Cecil County, Maryland, its elected and appointed officials, officers, agents, employees, and volunteers (herein called Cecil County), **Healthy Lifestyles Fitness Center** and any services, class or activity offered through the Department of Community Services (herein called course/activity), I understand and agree that:

1. I acknowledge that I have been advised of medical risks that may result from such participation and I represent to Cecil County that I have consulted my personal physician or other health authority and am physically capable of such participation without injury.

2. I recognize the risks of illness and injury inherent in any activity and am participating in the course/activity upon the express agreement and understanding that I am hereby waiving and releasing Cecil County, its elected and appointed officials, officers, agents, employees and volunteers from any and all claims, costs, liabilities, expenses or judgments, including attorneys' fees and court costs (herein, collectively referred to as "Claims") arising out of my participation in the aforesaid course/activity or any illness, injury or death resulting therefrom, and hereby agree to indemnify and hold harmless Cecil County from and against all such Claims except Claims proximately caused by the gross negligence or willful misconduct of Cecil County.

3. I understand that the **Healthy Lifestyles Fitness Center** staff reserves the right to exercise professional discretion when determining appropriate membership status. I recognize that all individuals may not be best served by joining the Healthy Lifestyles Fitness Center. *Further, I understand the **Healthy Lifestyles Fitness Center** is not a medically based fitness facility, nor is it to be considered a physical therapy facility or a substitute for a prescribed therapy program.*

4. I hereby execute and deliver this waiver and release voluntarily and with full understanding of the contents and consequences thereof and to induce Cecil County to participate in this program.

_____ _____
Signature of Participant Date

_____
Print Name of Participant

_____
Street Address

_____ _____ _____
City State Zip Code

_____ _____
Home Phone Work Phone

INFORMATION RELEASE FORM

Some of the information collected in this form may be shared with the Maryland Department of Aging (MDoA) and the Department of Community Services (DCS).

The Healthy Lifestyles Fitness Center and DCS **will not voluntarily share any personal information which identifies you (such as your name, address or telephone number) with any other person or organization.** However, the Healthy Lifestyles Fitness Center and DCS may use information such as attendance, increased strength, improved wellness, etc. for research and funding purposes or to support the premise of healthy, active aging within the community. All personal information will be kept in a secure location to protect your privacy.

In the event of a medical emergency, I give DCS permission to share my personal information with First Responders and/or Emergency Services personnel for the purpose of assisting in my care.

You may refuse to share certain specific identifying information on this form.

You may inspect your personal information at the Healthy Lifestyles Fitness Center, 200 Chesapeake Blvd., Elkton, MD 21921 (410-620-3101),

☐ *I have read the above notice and give my consent for the Healthy Lifestyles Fitness Center to share information with emergency responders, DCS and/or MDOA for the exact purposes mentioned above.*

☐ *I have read the above notice and DO NOT give my consent for the Healthy Lifestyles Fitness Center to share information with emergency responders, DCS and/or MDOA for the exact purposes mentioned above.*

_____ _____

Signature Date