WELCOME TO THE *DUKE HEALTH & FITNESS CENTER!*

MEMBERSHIP APPLICATION

Please complete the following information to help us better serve you

____ ____________________________ ___________

Name: (Last) **(First)** **(MI)**

_____/_____/_____ ________ __________ ____________________ ______________________

Birthdate **Age** **Gender** **Daytime Phone Number** **Evening Phone Number**

_________________________ ***Please circle preferred method of contact**

E-mail address

____

Mailing/Billing Address **City** **State** **Zip Code**

________________________________ ____

Primary Occupation **EmergencyContact** **Phone Number**

______________________________ ________________ ______________________________

Personal Physician **Office Phone/Fax #** **Date of Last Physical Exam**

How did you find out about the Duke Health & Fitness Center?

- ☐ Friend is a member
- ☐ Physician Referral
- ☐ Former Cardiac Rehab Client
- ☐ Duke employee
- ☐ Family/Spouse is a member
- ☐ Former Pulmonary Rehab Client
- ☐ Web Page
- ☐ Past Member
- ☐ Former Physical Therapy Patient
- ☐ Special Promotion, please specify ________________________
- ☐ Former Arthritis Client

Time you are most likely to exercise:

☐ **6 AM** ☐ **8 AM** ☐ **10 AM** ☐ **NOON** ☐ **2 PM** ☐ **5 PM**

What is your primary reason for joining the Duke Health & Fitness Center?

____
____
____
____

Please check any of the following activities you might be interested in:

Group Exercise Classes

______Land Aerobics _____ Water Exercise Classes _____ Mind/Body Classes (yoga, pilates, etc.)

_____ Arthritis Pool Classes _____ Strength/Flexibility Classes _____ Indoor Cycling

Other

______ Cardiovascular Equipment _____ Strength Training _____ Other, please list: __________________

Please check any of the following services you might be interested in (some at additional cost):

_____ Personal Training _____ Massage Therapy _____ Weight Loss Programming

_____ Nutrition Programming _____ Smoking Cessation _____ Stress Management Programming

_____ Physical Therapy _____ Arthritis Program _____ Health Psychology/Behavioral Counseling

PLEASE READ CAREFULLY BEFORE SIGNING:

I certify that all statements made on this application are accurate and that my answers to questions on the medical screening questionnaire are complete and true to the best of my knowledge. I understand that any misrepresentation or misinformation in this application/questionnaire could result in the rejection of my application, and could ultimately result in revocation of my membership. I understand that, based on my current symptoms or my medical condition, I may be required to have clearance from a physician, including a baseline medical examination and/or an exercise stress test or screening fitness test before my membership application can be accepted. I understand that additional costs may be incurred based upon services rendered. I authorize my personal physician and any other medical facility to release my medical records for review by appropriate staff at Duke Health & Fitness Center.

____ ________/________/_______

Member Signature **Date**

HEALTH HISTORY QUESTIONNAIRE

Read carefully and answer all questions. If you answer "Yes" to 2 or more of the questions indicated by "*", you will need a physician's clearance. The form is attached to the application. (**In some cases a clearance may be required due to other risk factors not indicated prior to membership appointment).**

YES NO

☐ ☐ ***Are you a male age 45 or older, OR are you a female age 55 or older?**

☐ ☐ *Have you ever regularly smoked cigarettes?

If yes, do you currently smoke cigarettes?

☐ YES Packs/day: ____________ Years Smoked: ____________

☐ NO Date Quit: __________ Packs/day: __________ Years Smoked: ____________

☐ ☐ *Do you have, or have you EVER had High Blood Pressure (>140/90)

Are you taking medication for this? Yes No

Do you know your last blood pressure reading? Yes No BP: ____________

☐ ☐ *Do you have elevated blood sugar or diabetes? If yes, is your diabetes:

☐ well controlled

☐ not very well controlled

☐ not sure

Do you take insulin to control your diabetes? Yes No

Do you take a pill (oral agent) to control your diabetes? Yes No

Is your diabetes controlled by diet alone? Yes No

☐ ☐ *Do you have high blood cholesterol (>200 mg/dl) or low HDL cholesterol (< 40 mg/dl)?

Are you taking medication for this? Yes No

Do you know your last cholesterol reading? Yes No

Total: _____________ HDL: __________

☐ ☐ *Has any member of your immediate family (parents, brothers, sisters) developed heart disease or had a stroke before age 55?

☐ ☐ *Do you currently experience chest pain, or a numbness or ache in your left arm, jaw or neck at rest or during physical activity?

☐ ☐ Do you lose your balance because of dizziness or do you ever lose consciousness (faint)?

☐ ☐ *Do you currently experience shortness of breath when performing daily activities or upon mild exertion, or wake up suddenly with shortness of breath?

☐ ☐ Have you ever had an exercise stress test? If yes, what year? ___________

YES NO

☐ ☐ Are you a post menopausal female NOT currently on hormone replacement therapy?

☐ ☐ Do you have a family history of osteoporosis?

☐ ☐ Have you had a fall in the past 3 months?

If yes, how many times did you fall in the past 3 months? ____________

What type of assistive device do you use to help you get around at home? (check all that apply):

☐ None	☐ Single point cane
☐ Four-footed cane	☐ Standard Walker
☐ Walker with 2 front wheels	☐ Rollateor (3 to 4 wheeled) rolling walker
☐ Manual wheelchair	☐ Power wheelchair or scooter

☐ ☐ Are you currently under a physician's care for an active or chronic medical condition?

Date of last visit: ______________ Condition(s): ___________________________

☐ ☐ Have your symptoms changed since your last appointment with your primary physician?

☐ ☐ Do you know of any reason why you should not do physical activity?

If yes, why? ____

☐ ☐ *Has a physician ever told you that you have (or have had) **Heart Disease** (heart attack, surgery, heart murmur, irregular heart beats, angina, heart failure, etc.) OR **Vascular Disease**?

IF **YES**, please check which condition(s) you have (or have had):

YES NO

☐ ☐ Heart attack (when?__________________)

☐ ☐ Coronary Artery Bypass Surgery (when? ______________)

☐ ☐ Angioplasty (PTCA) or Stent placement (when? _________________)

☐ ☐ Angina (chest pain/discomfort) If yes, how many episodes in a week?_________

How many SL Nitroglycerin pills do you take per week?_______

☐ ☐ Irregular Heart Beats

☐ ☐ Heart Failure (when? _________________)

☐ ☐ Heart Murmur or valvular heart disease (what valve? __________________)

☐ ☐ Heart Valve Surgery (what valve? ____________________) (when? _____________)

☐ ☐ Pacemaker Implant (when? _______________)

☐ ☐ AICD Implant (when? _________________)

☐ ☐ Stroke or TIA (when?_______________________)

☐ ☐ Peripheral Vascular Disease

Have you ever been told by a physician that you have any of the following medical conditions:

YES	NO	
☐	☐	Thyroid/Kidney/Liver Disease? (Circle) (when?_________________)
☐	☐	Bronchitis/Emphysema/Asthma or other Lung Disease (Circle)
☐	☐	Ulcer/Colon Disorder (Circle) (when?____________________)
☐	☐	Cancer What type?_____________________ (when?______________) (current status?___________________)
☐	☐	Seizures (when?____________________________)
☐	☐	Chronic or Severe Headaches (when?____________________________)
☐	☐	Arthritis What type?___________________________ Joint(s) affected? _________________________
☐	☐	Osteoporosis
☐	☐	Chronic Orthopedic Problem Specify : ____________________________ (when?__________________)
☐	☐	Major Injury Specify: ______________________________ (when?_____________________)

If needed, use this space to further explain YES responses:

____

____

____

Please list all major surgery you have had as well as any surgery in the past year (please include dates)

____

____

Please list all medications you are currently taking:

Medication Name	Dose	Frequency
example: tenormin	*25mg*	*3 times a day*

Allergies: ____

____

Exercise:

- How would you describe your daily activity:

( ) Sitting most of day ( ) Light activity ( ) On feet 6-8 hrs/day ( ) Manual Labor 6-8 hrs/day

- Describe your current exercise routine:
  - Aerobic Activities: ____
  - Strenth/Resistance Activities: ____
  - Stretching/Flexibility Activities: ____

Nutrition:

- What is your present weight? ___________lbs What is your present height? _____________
- How long have you maintained your present weight? _____ yrs _____ months
- Are you satisfied with your current weight ? ( ) Yes ( ) No
- Ideally, what would you really like to weigh now? ______ lbs
- Do your daily food choices contribute to a healthy lifestyle? ( ) Yes ( ) No

Stress Management:

- Overall, how stressful is your life? (Circle One.)

Very Stressful Moderately Stressful Mildly Stressful Not Stressful

- In which areas do you experience significant stress? Check all that apply.

☐ Employment-related stress ☐ Social/interpersonal concerns

☐ Family-related stress ☐ Financial worries

☐ Health-related stress ☐ Other (Please specify: ______________________________)

- How effective are you with managing your stress? Check the one that best fits you now:

☐ Very effective (I've got stress under control.)

☐ Somewhat effective (I've got a handle on stress, but could benefit from more ideas or support in coping with it.)

☐ Ineffective (I need to learn some new ways to cope with stress.)

☐ Very ineffective (My stress is overwhelming and I need help coping now.)

Lifestyle Changes:

- How interested are you in making lifestyle changes in each of the following areas?

	Very Interested	Moderately Interested	Somewhat interested	Not very interested	Not at all interested
Exercising					
Losing Weight					
Changing my diet					
Managing Stress					
Quitting Smoking					
Improving Relationships					

- How likely is it that you will actually make changes in the following areas?

	Very Likely	Moderately Likely	Somewhat Likely	Not very Likely	Not at all Likely
Exercising					
Losing Weight					
Changing my diet					
Managing Stress					
Quitting Smoking					
Improving Relationships					

- How much control do you believe you have over the following?

	Complete	Very Much	Some	Not much	None
Exercising					
Losing Weight					
Changing my diet					
Managing Stress					
Quitting Smoking					
Improving Relationships					

Is there anything else you would like to tell us about yourself that would help us to assist you in making positive lifestyle changes at the Duke Health & Fitness Center?

____

____

____

Duke Health & Fitness Center
DUKE UNIVERSITY HEALTH SYSTEM

Physician's Statement and Clearance Form

On the Health History Questionnaire you just completed, you identified that you have one or more coronary and/or other medical risk factors which may impair your ability to exercise safely. For this reason, you need to have a physician complete and return this medical clearance form before you can begin exercising at Duke Health & Fitness Center.

We recognize that you are eager to start you fitness program, and we sincerely regret any inconvenience that this may cause you. However, please keep in mind that we want your exercise experience at Duke Health & Fitness Center to be as safe as possible.

In order to expedite this process, we will gladly fax this form directly to the physician of your choice. If the doctor is aware of your medical history, he/she may be able to complete this form and fax it right back to us.

I hereby give my physician permission to release any pertinent medical information from any medical records to the staff at Duke Health & Fitness Center. All information will be kept confidential.

Patient signature____ Date____________________

Information requested for ____
Reason for medical clearance____
Physicians name_________________ Phone_____________ Fax_________
Address____

For Physician Use Only

Please check one of the following statements:

☐ **I concur with my patient's participation with no restrictions.**
☐ **I concur with my patient's participation in any exercise program if he/she restricts activities to:**

____

____

☐ **I do not concur with my patient's participation in any exercise program (if checked, the individual will not be allowed to join Duke Health & Fitness Center.**

Reason____

☐ **It is my medical judgment that my patient requires an ETT prior to starting his/her exercise program.**
- Please make an appointment for my patient at The Wallace Clinic, at The Center for Living.
- My office will make an appointment for my patient.

Physician's name (type or print)____

Physician's signature___________________ Date____________________

Please return fax to: Jamont Beatty at 919-681-7467

Duke Health & Fitness Center
DUKE UNIVERSITY HEALTH SYSTEM

Agreement and Release of Liability

1. In consideration of gaining membership or being allowed to participate in the activities and programs of the Duke Health & Fitness Center and to use its facilities, equipment, and machinery in addition to the payment of any fee or charge, I do hereby waive, release and forever discharge Duke Health & Fitness Center and its officers, agents, employees, representatives, executors, and all others from any and all responsibilities or liability for injuries or damages resulting from my participation in any activities or my use of equipment or machinery in the above-mentioned facilities or arising out of my participation in any activities at said facility. I do also hereby release all of those mentioned and any others acting upon their behalf from any responsibility or liability for any injury or damage to myself, arising out of or connected with my participation in any activities of the Duke Health & Fitness Center or the use of any equipment at Duke Health & Fitness Center.

2. I understand and am aware that strength, flexibility, and aerobic exercise, including the use of equipment, is a potentially hazardous activity. I also understand that fitness activities involve a risk of injury and even death and that I am voluntarily participating in these activities and using equipment and machinery with knowledge of the dangers involved. I hereby agree to expressly assume and accept any and all risks of injury or death.

3. I do hereby further declare myself to be physically sound and suffering from no condition, impairment, disease, infirmity, or other illness that would prevent my participation in any of the activities and programs of the Duke Health & Fitness Center or use of equipment or machinery except as hereinafter stated. I do hereby acknowledge that I have been informed of the need for a physician's approval for my participation in an exercise/fitness activity or in the use of exercise equipment and machinery. I also acknowledge that it has been recommended that I have a yearly or more frequent physical examination and consultation with my physician as to physical activity, exercise, and use of exercise and training equipment so that I might have recommendations concerning these fitness activities and equipment use. I acknowledge that I have either had a physical examination and have been given any physician's permission to participate, or that I have decided to participate in activity and/or use of equipment and machinery without the approval of my physician and do hereby assume all responsibility for my participation and activities, and utilization of equipment and machinery in my activities.

Date ____________________ Signature ____

DUKE CENTER FOR LIVING/DIET AND FITNESS CENTER
CLIENT/GUEST CODE OF CONDUCT

The staff of the Duke Center for Living/Diet and Fitness Center is committed to providing high quality patient care and a therapeutic environment to provide effective programming for all clients. Clients are expected to conduct themselves in an appropriate manner at all times while participating in DCL/DFC programs. The following standards of conduct apply to all clients during their program participation as well as to all guests during their visit at either campus. Guests are defined as individuals on either campus that are non-paying clients.

1. The client must conduct himself in an appropriate manner while in a program or within any facility on the DCL/DFC campus. Clients are expected to be respectful of other participants and staff.

2. Clients may not use profane, abusive or loud/boisterous language while on the premises or engage in any action, which may be discourteous or harmful to others.

3. Clients are required to interact appropriately with other clients, staff, guests, vendors and others while on the premises. Their behavior should in no way violate another person's sense of privacy or dignity.

4. Clients may not make threats, fight, or engage in any inappropriate or unwanted physical contact with another person while on the premises.

5. Clients suspected to be under the influence of alcohol or illegal drugs will not be allowed admission into any of the facilities.

6. Clients are encouraged to follow program goals and exhibit full participation in all appropriate program activities.

7. Clients are encouraged to respect the program goals of other participants by not encouraging activities contrary to program standards.

8. Clients are expected to maintain confidentiality regarding any other client’s program participation.

I have read the above Code of Conduct and agree to abide by these rules while participating in any DCL/DFC program. I understand that violations of any of these rules may result in or termination of my participation in any program.

______________________________ ______________________

Signature Date