

# Next Step Health and Fitness Center

208-03 Union Turnpike, Hollis Hills, New York 11364

nextstephealth@verizon.net

Last Name: \_\_\_\_\_ First: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_

DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Gender: Male  Female

(H) Phone :( ) \_\_\_\_\_ - \_\_\_\_\_ (W) Phone :( ) \_\_\_\_\_ - \_\_\_\_\_

E-mail address: \_\_\_\_\_@\_\_\_\_\_

Occupation: \_\_\_\_\_

Emergency contact: \_\_\_\_\_ Relationship with contact: \_\_\_\_\_

Emergency contact number: ( ) \_\_\_\_\_ - \_\_\_\_\_

## Medical History (circle/list all that apply)

1. When was the last time you had a physical exam? Date \_\_\_\_/\_\_\_\_/\_\_\_\_
2. Has your doctor ever diagnosed you as having heart disease, stroke, diabetes or epilepsy?
3. Have you ever had any back problems, arthritis, or orthopedic problems?
4. Are you pregnant, or do you have any reason to believe you are?
5. List any other medical problems you may have:

## PAR-Q

1. Has your doctor ever said that you have a heart condition and that you should only do physical activity recommended by a doctor?
2. Do you feel pain in your chest when you do physical activity?
3. In the past month, have you had chest pain when you were not doing physical activity?
4. Do you lose your balance because of dizziness or do you ever lose consciousness?
5. Do you have a bone or joint problem that could be made worse by a change in your physical activity?
6. Is your doctor currently prescribing drugs (for example, water pills) for your blood pressure or heart condition?
7. Do you know of any other reason why you should not do physical activity?

**Cardiovascular History**

	YES	NO
Have you ever had a heart attack?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had angioplasty or bypass surgery?	<input type="checkbox"/>	<input type="checkbox"/>
Has your doctor ever told you of a heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have high cholesterol?	<input type="checkbox"/>	<input type="checkbox"/>
Have you been told of an abnormal EKG?	<input type="checkbox"/>	<input type="checkbox"/>
Are you diabetic?	<input type="checkbox"/>	<input type="checkbox"/>
Do you smoke cigarettes?	<input type="checkbox"/>	<input type="checkbox"/>
Do you/have you experienced heart palpitations?	<input type="checkbox"/>	<input type="checkbox"/>
When was your last stress test?	____/____/____	

**Orthopedic History**

Check off any of the following conditions you are currently suffering or have suffered from:

Arthritis	<input type="checkbox"/>	Ankle/Foot injury	<input type="checkbox"/>	Shoulder injury	<input type="checkbox"/>
Low back pain	<input type="checkbox"/>	Arm/elbow injury	<input type="checkbox"/>	Knee injury	<input type="checkbox"/>
Calcium deficiency	<input type="checkbox"/>	Nerve damage	<input type="checkbox"/>	Spinal injury	<input type="checkbox"/>
Head/neck injury	<input type="checkbox"/>	Wrist/hand injury	<input type="checkbox"/>	Hip/pelvis injury	<input type="checkbox"/>
Other	<input type="checkbox"/>				

Explain:

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**Medications and Dietary Supplements**

Name of medication/supplement	Reason
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____
6. _____	_____
7. _____	_____

**Release and Waiver**

I know of no physical or medical condition which I, or my doctor, feel could be aggravated by using the equipment and facilities in participating in activities sponsored by this club. I agree to advise club management in writing if any of the above information changes or if my doctor advises me to stop, reduce or otherwise adjust my exercise regimen at the club. I will advise club management immediately if I injure myself in any way while on club property. The information I have given in this form is, to the best of my knowledge, complete and accurate.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_