

## SANFORD WELLNESS CENTER / FAMILY WELLNESS HEALTH QUESTIONNAIRE

Name		Birth Date	
Address		Email	
City/State		Zip	
Phone (Home)		Phone (Cell)	
Emergency Contact		Phone	
Physician		Hospital	
Membership #		Trainer	
Appointment Time/Date			

1. Please indicate if you have been diagnosed with any of the following:	YES	NO
Heart Disease Medications:		
Hypertension (High Blood Pressure) Medications:		
Stroke Medications:		
Epilepsy or Seizures Medications:		
COPD (Chronic Obstructive Pulmonary Disease) Asthma or Emphysema Medications:		
Diabetes <input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2 Medications: Insulin      Oral      None		
2. Have you experienced chest pain due to physical activity?		
3. Have you experienced chest pain within the last month?		
4. Have you lost consciousness or fallen as a result of dizziness?		
5. Are you under a doctor's supervision for any illness or physical condition that may affect your ability to exercise? Explain:		
6. Are you pregnant or post-natal? Due Date:		
7. Do you have muscle/bone/joint problems that are aggravated by exercise? Please explain: Does it affect your ability to exercise?		
8. Allergies: Please list Medications:		

Staff Use Only:	
<input type="checkbox"/> Cleared to exercise	<input type="checkbox"/> Not cleared to exercise
Reason: _____	
Staff Signature: _____	Date: _____

**EXPRESS ASSUMPTION OF RISK, WAIVER AND INDEMNIFICATION OF LIABILITY**

Member represents that Member and Member’s family and guests, are physically able and qualified to participate in physical activities and the use of the facilities provided by the Sanford Wellness Center/Family Wellness. Member acknowledges and agrees that all activities and use of the Sanford Wellness Center/Family Wellness’s services and facilities by Member and Member’s family and guests are accepted “as is” and shall be undertaken at the sole risk of Member. Member understands that there is risk involved in physical activities, including risks of bodily injury, partial or total disability, paralysis and death, as well as other foreseeable and unforeseeable damages, including damage to property. Member understands that there is also a very remote possibility that Member might be exposed to bodily fluids (i.e., blood) which may contain the Hepatitis B agent or HIV virus. Member knowingly and voluntarily acknowledges Member’s full understanding of said risks and assumes such risks on behalf of Member and Member’s family and guests.

On behalf of Member and Member’s family and guests, and their respective heirs, executors, administrators and assigns, Member hereby waives and relinquishes any claims, rights and causes of action that Member or Member’s family or guests may have against the Sanford Wellness Center/Family Wellness or Sanford USD Medical Center and Sanford Health and its affiliates, trustees, employees, agents, successors and assigns, for any injuries or damages to Member or to Member’s family or guests, arising out of the use of the Sanford Wellness Center / Family Wellness services or facilities, whether or not arising from acts of active or passive negligence on the part of the Sanford Wellness Center / Family Wellness, its employees or agents.

On behalf of Member and Member’s family and guests, and their respective heirs, executors, administrators and assigns, Member hereby agrees to indemnify and hold harmless the Sanford Wellness Center/Family Wellness or Sanford USD Medical Center and Sanford Health and its affiliates, trustees, employees, agents, successors and assigns, from any and all claims, demands, actions, costs or causes of action, including attorneys fees and costs of defense, relating to any such injuries and damage arising out of or connected with Member’s use or use by Member’s family or guests, of any of the Sanford Wellness Center services or the premises where the same are located wherever or however they occur.

Member hereby gives authorization to the Sanford Wellness Center/Family Wellness staff to act in accordance with their best judgment in case of any injury or emergency that may occur for Member, Member’s family or guests. Should medical care be necessary, Member agrees to pay the reasonable cost of such medical care or treatment.

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

