



REGISTRATION AND MEDICAL SCREENING FORM

Name: _____
LAST FIRST

Address: _____
STREET ADDRESS CITY STATE ZIP

Preferred Phone: _____ Birth Date: _____

Age: _____ Sex: **MALE / FEMALE** Occupation: _____

Email: _____ Monthly newsletter? **YES / NO**

Are you interested in any of the following services?

- Personal Training
- Group Classes
- Massage Therapy
- Nutrition Counseling and Education

Do you agree with any of these statements?

1. I desire accountability from the wellness staff to help me reach my goals. Y/N
2. I would appreciate encouragement from the wellness staff. Y/N
3. I wish to be independent during my workouts at OrthoGeorgia Wellness. Y/N

Date of Last Physical Exam: _____

Physician's Name: _____

Physician's Phone: _____ Physician's Fax: _____

EMERGENCY CONTACT: _____

PHONE: _____ RELATION: _____

MEDICAL HISTORY. PLEASE ANSWER HONESTLY AND COMPLETELY.

1. I have or have had a heart attack, heart surgery (including a catheter or angioplasty), heart transplant, pacemaker or similar device, heart disease, or heart failure. Y/N
2. I have diabetes. Y/N
3. I have asthma or another lung disease or breathing problems. Y/N
4. I have burning or cramping in my legs when I walk short distances. Y/N
5. I have a musculoskeletal problem that sometimes limits my activities. Y/N
6. I take prescription medications for my heart, cholesterol, diabetes, asthma, or other medical condition. Y/N
7. I have epilepsy or seizures. Y/N
8. I have a recent or present hernia. Y/N
9. I have experienced chest discomfort when I exert myself (i.e. exercise). Y/N
10. I am pregnant. Y/N

*** If you answered "yes" to any questions numbered 1-10, you MUST get a physician referral form filled BEFORE you schedule your assessment or begin using wellness equipment.**

11. I experience extreme breathlessness. Y/N
12. I experience dizziness, fainting, or blackouts. Y/N
13. I have recently (within the past 6 months) had surgery. Y/N
14. I am a man older than 45. Y/N
15. I am a woman older than 55. Y/N
16. I smoke or quit within the past six months. Y/N
17. My blood pressure is greater than 140/90, I have been told I have hypertension, or I take blood pressure medication. Y/N
18. I know my blood pressure. Y/N_____
19. My cholesterol is greater than 200 mg/dl ?
20. I know my cholesterol level. Y/N_____
21. I have concerns about the safety of exercise. Y/N

LIST ALL MEDICATIONS YOU ARE TAKING (prescription and OTC)

SIGNATURE: _____

DATE: _____



OrthoGeorgia Wellness
Fax: 478-750-6626
3708 Northside Drive

PHYSICIAN REFERRAL FORM

Please complete and return to OrthoGeorgia Wellness

Participant's Name: _____ Date: _____

Participant's Birth Date: _____ Age: _____

TO BE ANSWERED BY YOUR FAMILY PHYSICIAN:

1. Date of last physical examination _____
2. Are there any contraindications to exercise for this individual (etiologic factors which would be absolute contraindications to participation in the OrthoGeorgia Wellness Program)? YES / NO
3. Are there any risk factors the Wellness staff should be aware of regarding this individual? YES / NO
4. Are there any medications that may interfere with or be affected by an exercise program? YES / NO
5. If yes, please list: _____
6. Other abnormalities you are aware of? _____

Based upon the current review of the health status of _____,
I recommend:

- No physical activity
- Stress Testing prior to beginning an exercise program
- Progressive physical activity
 - with the avoidance of _____
 - other recommendations _____
- Unrestricted physical activity

Signed: _____ Date: _____

Physician Name: _____ Phone: _____



Informed Consent

INFORMED CONSENT FOR PARTICIPATION IN HEALTH-RELATED EVALUATION AND WELLNESS TRAINING

Information you possess about your health status or previous experiences of unusual feelings with physical effort may affect the safety and value of your evaluation/training program. Your prompt reporting of feelings with effort during evaluation/training are also of great importance. You are responsible to fully disclose such information when requested by the wellness staff. Any questions about the procedures used in the evaluation/training are encouraged. If you have any doubts or questions, please ask us for further explanations.

Your permission to perform this evaluation/training is voluntary. You are free to deny consent or stop the program at any point, if you so desire.

PLEASE CAREFULLY READ THE FOLLOWING STATEMENT AND SIGN BELOW:

I hereby request the opportunity to participate in health and fitness evaluation/training consisting of physical exercise. I hereby acknowledge that my participation in this program is entirely voluntary on my part. Such participation is solely for my own pleasure and benefit.

It is possible that certain unhealthy changes may occur during the evaluation/training. They include abnormal blood pressure, fainting, disorder of heart beat, and in rare instances, heart attack or stroke.

I WILL NOT HOLD ORTHOGEORGIA, OR ANY OF ITS EMPLOYEES, LIABLE FOR ANY INJURY (INCLUDING DEATH) I MAY SUSTAIN AS A RESULT OF THIS EVALUATION/TRAINING PROGRAM.

I have read this form and I understand the testing procedures that I will perform. I consent to participate in this evaluation and wellness training program.

Signature

Date