



Date Completed: \_\_\_\_\_

Tour Guide: \_\_\_\_\_

Joined Fitness Center: Yes  No

### MEMBERSHIP INTAKE FORM

First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Last Name: \_\_\_\_\_ Nickname: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Are you 60 years of age or older? Yes or No

Gender Assigned at Birth: \_\_\_\_\_ Gender Identity: \_\_\_\_\_

Primary Phone Number: \_\_\_\_\_ Cell Phone Number: \_\_\_\_\_

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

Home Address: Street 1: \_\_\_\_\_

Street 2: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

County: \_\_\_\_\_ Tax Municipality/Twp./Boro.: \_\_\_\_\_

Marital Status: Single Married Divorced Widowed

Are you a veteran? Yes or No

Do you have a disability? Yes or No

Ethnicity: \_\_\_\_\_

In poverty? Yes or No

Would you like to order a lunch today? Yes or No

Emergency Contact:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone Number: \_\_\_\_\_

How did you learn about us? \_\_\_\_\_

\_\_\_\_\_

## NUTRITIONAL ASSESSMENT

Please circle "YES" or "NO"	YES	NO
1. I have an illness that made me change the kind of food I eat.	2	0
2. I eat fewer than two meals per day.	3	0
3. I eat few fruits, vegetables or milk products.	2	0
4. I have 3 or more drinks of beer, liquor, or wine at most each day.	2	0
5. I have tooth or mouth problems that make it hard to eat.	2	0
6. I don't always have enough money to buy the food I need.	4	0
7. I usually eat alone.	1	0
8. I take 3 or more prescribed or over-the-counter medications a day.	1	0
9. Without effort, I have lost or gained 10 pounds in the last 6 months.	2	0
10. I am not always physically able to shop, cook and/ or feed myself.	2	0

Scoring information:

Total Score: \_\_\_\_\_

[0-2 Low Risk / 3-5 Moderate Risk / 6+ High Risk]

### CENTER AT THE MALL FITNESS PROGRAM RELEASE

I understand that there are risks involved with any exercise program. These risks include but are not limited to: cardiovascular complications, stroke, and muscle strain/soreness. I agree to voluntarily participate in the Center at the Mall (CATM) fitness program knowing that these risks exist. I state that I do not have any medical conditions that would restrict my participation in the exercise(s) identified as the "Center at the Mall Fitness Program," or that I have permission from my doctor to engage in unsupervised physical activity. I realize that the use of the fitness center is a privilege and failure to follow proper procedures and policies will result in loss of this privilege. I have been instructed to avoid exercise(s) that cause discomfort, pace myself by taking breaks as needed, and immediately report any abnormal signs and symptoms to the appropriate personnel. I release Lutheran SeniorLife/CATM/Beaver County Office on Aging/Lutheran Service Society and associated personnel from any responsibility or liability that may result from my participation in group classes or from my use of the fitness center. My signature indicates that I understand the physical risks involved in the program, that I agree to participate with knowledge of the risks, and that I hereby release Lutheran SeniorLife/CATM/Beaver County Office on Aging/Lutheran Service Society as stated above from any and all responsibility.

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



Date Completed: \_\_\_\_\_

Tour Guide: \_\_\_\_\_

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Please check the following member status upon the completion of paperwork:

- New CATM Center Member
- New Fitness Center Member
- Previous Fitness Center Member with Lapse/Change in Membership

Membership Type (CHECK ONE): \_\_\_\_\_

- 1 Year Self Pay Membership \$ \_\_\_\_\_ Cash / Check / Card
- 6 Month Self Pay Membership \$ \_\_\_\_\_ Cash / Check / Card
- 3 Month Self Pay Membership \$ \_\_\_\_\_ Cash / Check / Card
- 12 Visit Punch Pass
- Fit On Health Fitness ID#: \_\_\_\_\_
- SilverSneakers Fitness ID #: \_\_\_\_\_
- Renew Active Fitness ID #: \_\_\_\_\_

*It is the policy of Lutheran Service Society and the Beaver County Office on Aging to grant prorated refunds for the Fitness Center with proper medical documentation.*

## Fitness Center Policies & Rules

1. All members must check-in at the Fitness Center desk.
2. SilverSneakers Fitness Program members are required to swipe their card each time they attend classes, use the fitness center gym, or participate in any wellness related classes or events.
3. All exercisers should wear rubber soled shoes. NO sandals/flip flops, shoes with heels, dress shoes, boots, or metal soled shoes are permitted.
4. On days with snowy/rainy weather, please bring a second pair of shoes to change into for exercise.
5. Exercise clothing should be loose fitting and comfortable.
6. After each use, please use the disinfectant to wipe off equipment seats, pads, rails and controls.
7. If equipment is malfunctioning, please notify a staff member immediately.
8. Please do not leave keys or other sharp objects in your back pockets, as this damages equipment seats.
9. We are NOT responsible for lost or stolen items.
10. Remember...if it hurts, don't do it! If any exercise causes pain, you should skip that particular exercise. If the pain persists, inform the fitness staff and see your personal physician.
11. If there is an emergency, immediately notify the staff on duty. DO NOT attempt to help anyone up who has fallen. Encourage him/her to lie still and wait until help arrives.
12. If you experience pain in your chest, shoulder, arm, jaw, head or you feel nauseated, dizzy or light headed while exercising or immediately after exercising, promptly report these symptoms to the fitness staff.

## Exercise Readiness Questionnaire

Yes No

1. Has a doctor ever recommended medically supervised exercise?
2. Have you had chest pain recently or does physical activity cause you to experience chest pain?
3. Have you on one or more occasions lost consciousness or fallen over as a result of dizziness?
4. Are you aware, through your own experience or a doctor's advice, of any physical reason that would prohibit you from exercising without medical supervision?

If you answered "yes" to any of the questions above, you are required to provide a completed Medical Clearance Form signed by both you and your doctor.

If you are older than 69 years of age, it is *recommended* that you speak with your doctor before participating in our fitness program. This will not be required for membership.

If you answered "no" to all of these questions there is no further action needed except to sign this form.

Print Name: \_\_\_\_\_

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

Your signature signifies that you answered all of the above questions honestly and to the best of your knowledge.