PRESBYTERIAN

Welcome to the Healthplex!

PROGRAM - **Please check program that applies to you. If unsure, please ask our staff.**

☐ **Aftercare** ☐ **Employee Health** ☐ **Pulmonary Rehab** ☐ **Lung Gym**
☐ **Cardiac Rehab** ☐ **Health Improvement** ☐ **Prenatal/Post-Partum** ☐ **Pool**
☐ **Cardiac Maintenance III, IV** ☐ **Senior Health** **_____ (initial)**

PERSONAL INFORMATION **TODAY'S DATE** ___ / ___ / ___

Name: _____ Birthdate: ___ / ___ / ___ Age: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: (home) _____ (work) _____

Email Address: _____ Gender: ☐ Male ☐ Female

Race: (optional) ☐ **White/Caucasian** ☐ **Hispanic** ☐ **Asian**
☐ **Native American** ☐ **Black/African American** ☐ **Other**

☐ **Employed** ☐ **Retired** ☐ **Disabled**

Former or current occupation: _____

Marital Status: ☐ Single ☐ Married ☐ Widowed; Spouse's Name: _____

Emergency Contact Name: _____

Phone: _____ Relationship: _____

PHYSICIAN CONTACTS

Primary Care Physician: _____ Phone: _____

Referring Physician: _____ Phone: _____

Other Physicians (include specialty): _____ Phone: _____

HEALTH INSURANCE COMPANY: _____

HEALTH HISTORY QUESTIONNAIRE

1. Have you had any of the following heart or blood vessel conditions?

- ☐ Aneurysm
- ☐ Angina (Chest Pain)
- ☐ Angioplasty (PTCA)
- ☐ Angioplasty with Stent
- ☐ Atrial Fibrillation
- ☐ Blood Clots _____
- ☐ Bypass Surgery (CABG)
- ☐ Cardiomyopathy
- ☐ Congenital Heart Disease
- ☐ Congestive Heart Failure
- ☐ Coronary Artery Disease
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ Heart Rhythm Problems
- ☐ Heart Transplant Surgery
- ☐ Heart Valve Problem
- ☐ Implantable Defibrillator
- ☐ Pacemaker
- ☐ Pericarditis
- ☐ Stroke
- ☐ Other: _____

If you answered yes to any of the above, please explain (include dates when applicable)

_____

_____

2. Do you currently have or have you ever had any of the following signs or symptoms?

- ☐ Angina, Chest Pain / Pressure
- ☐ Dizziness / Fainting
- ☐ Swelling of Ankles
- ☐ Open Incision or Wound
- ☐ Shortness of Breath
- ☐ Palpitations
- ☐ Inflamed Incision
- ☐ Leg Pain

3. Do you have or have you ever had any of the following medical conditions?

- ☐ Anemia
- ☐ Back Pain
- ☐ Bone or joint issues
- ☐ Cancer
- ☐ Cerebral Palsy
- ☐ Chronic Fatigue
- ☐ Epilepsy
- ☐ Fibromyalgia
- ☐ Gastroesophageal Reflux
- ☐ Kidney Disease
- ☐ Multiple Sclerosis
- ☐ Muscular Dystrophy
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Parkinson's Disease
- ☐ Rheumatoid Arthritis
- ☐ Urinary Problems
- ☐ Other: _____

If you answered yes to any of the above, please explain (include dates when applicable)

_____

_____

4. Has a doctor told you that you have diabetes? ☐ Yes ☐ No

   If yes, do you take insulin for your diabetes? ☐ Yes ☐ No

   Do you check your blood sugar levels? ☐ Yes ☐ No

   Last A1c: _____ Date: _____

5. Do you have any form of the following pulmonary (lung) illnesses?

- ☐ Asthma
- ☐ Bronchiectasis
- ☐ Bronchitis
- ☐ COPD
- ☐ Cor Pulmonale
- ☐ Emphysema
- ☐ Lung Cancer
- ☐ Pleurisy
- ☐ Pneumonia
- ☐ Pulmonary Embolism
- ☐ Pulmonary Hypertension
- ☐ Pulmonary Fibrosis
- ☐ Sinusitis
- ☐ Sleep Apnea
- ☐ Tuberculosis

Oxygen use: ____ liters/minute _____ hours/day Circle uses: Daytime Night With Activity

Type of home system _____ Type of Portable _____ Continuous Flow or Pulsed

6. Do you have problems sleeping at night? □ Yes □ No If yes describe: _____

_____

Do you feel rested? ? □ Yes □ No

7. Do you currently smoke cigarettes, cigars, pipes or use chewing tobacco? □ Yes □ No

If yes, do you want assistance to quit? □ Yes □ No

If you smoked in the past, what age did you start? _____ Age when quit: _____

What was/is the average number of packs per day you smoke(d)? _____

If you tried to quit smoking, what method(s) have you tried? _____

Does anyone smoke in your household? □ Yes □ No

8. Please check if the following apply to you:

____ You are a man older than 45 years

____ You are a woman older than 55 years, have had a hysterectomy, or are postmenopausal

____ You smoke, or quit smoking within the previous 6 months

____ Your blood pressure is greater than 140/90 mm Hg

____ You do not know your blood pressure

____ You take blood pressure medication

____ Your cholesterol level is greater than 200 mg/dl

____ You do not know your cholesterol level

____ You have a close blood relative who had a heart attack or heart surgery before age 55 (father or brother) or age 65 (mother or sister)

____ You are physically inactive (less than 30 minutes of physical activity on at least 3 days a week)

____ You are greater than 20 pounds overweight

9. Please circle any of the following conditions experienced by your immediate blood relatives:

Diabetes High Blood Pressure High Cholesterol Stroke

10. How would you rate your stress / anxiety level? □ Low □ Average □ High

Would you like to speak to a staff nurse about anxiety concerns? □ Yes □ No

11. Do you feel safe at home? □ Yes □ No

Would you like to speak to a nurse about safety concerns? □ Yes □ No

12. Have you fallen within the last 30 days or do you fall often? □ Yes □ No

Members are expected to provide their own attendant to assist with mobility needs while visiting or working out at the Healthplex. Please discuss with our exercise staff if this is an issue for you.

13. Pain: Are you having pain at this time? □ Yes □ No Location & Description: _____

_____

Have you experienced pain or discomfort during exercise in the past? □ Yes □ No
If yes, please explain: _____

14. Please name all of your medications, their dosages, and how often you take them:
(for example: Zocor, 5 mg, 1 time a day)

_____
_____
_____
_____
_____

15. Allergies (include medication allergies): _____

16. Physical injuries / limitations: _____
Circle mobility aides you use: Cane Wheelchair Walker Crutches Braces Other: _____

17. Past surgeries (include dates): _____

_____

18. Do you have any of the following problems that might affect your learning? □ Yes □ No
□ Visual □ Hearing □ Reading □ Speech □ Learning

19. Would you like information about your conditions / illnesses / injuries? □ Yes □ No
If yes, please specify: □ Classes □ Handouts □ Videos □ One-on-One Learning

20. Please list other issues we should know about that might affect treatment and / or progress?
(i.e., language barriers, cultural or religious beliefs, scheduling, or transportation needs)

21. Please identify your personal fitness goals at the Healthplex:

Cardiovascular Fitness Goals

□ Improve endurance of the heart and lungs
□ Rehabilitation from heart surgery / procedure
□ Improve activities of daily living _____
(Please list specific activities you would like to improve)

Strength Fitness Goals

□ Physical independence
□ Improve posture
□ Reshape or tone body (improve muscular endurance)
□ Injury prevention or rehabilitation or joint replacement issues
□ Increase size of muscles or increase amount of weight lifted (improve strength)
□ Improve sports / activity performance *Sport(s) / Activity*: _____
□ Increase bone density (osteoporosis issues)

Additional Goals

□ Improve flexibility □ Improve diet / eating habits □ Decrease body fat / weight loss
□ Prepare for childbirth (i.e., strengthen back, etc.) □ Other _____

Pain Goal

Using a 0 to 10 scale, 0 being NO pain and 10 being the Worst Pain Possible, please specify the level of pain that is acceptable to you: _____

PRESBYTERIAN

PRESBYTERIAN HEALTHPLEX
GYM POLICIES, MAIN FACILITY

PARKING: **Please park in the East parking lot and enter the facility through the East lobby entrance. West parking close to rear entrances is reserved for clients with walking difficulties, walking devices, wheelchairs, and oxygen.**

DRESS: **Clothing should provide adequate coverage, be clean, comfortable and loose fitting. Shirts required. Supportive shoes that enclose the foot are required unless exemption allowed by staff. Staff maintains the right to refuse access to the gym because of inappropriate attire. PLEASE BE AWARE THAT THE HEALTHPLEX IS A FRAGRANCE FREE FACILITY!**

FEES: **No fees for Employees and their family members living in the same household. Contracted Employees, with a Presbyterian contractor's badge, no fee, however responsible to renew every six months. Contracted Employees without a Presbyterian contractor's badge will pay $16.00 per month.**

PRECAUTIONS: **Please be certain to inform exercise staff if any of the following occur:**

- ⇒ **Any unusual discomfort**
- ⇒ **Shortness of breath**
- ⇒ **Dizziness or nausea**
- ⇒ **New precautions from your physician**
- ⇒ **Changes in your medications**
- ⇒ **Spotting (Pregnancy ONLY)**

APPOINTMENTS: **Our phone number is 823-8399. Please call as soon as possible if you need to cancel or change an appointment.**

HOURS:

Monday - Thursday	**5:30 am - 8:30 pm**
Friday	**5:30 am - 7:30 pm**
Saturday	**7:00 am - 3:00 pm**

The Gym Equipment Is Reserved Exclusively For Program Participants 22.5 Hours A Week:
Pulmonary/Cardiac Rehab M-W-F 10:00am – 5:00 p.m.

SATELLITE: **Satellite locations are only accessible to employees; dependents can only use the Main Facility.**

Participant Signature: _____ Date: _____

Witness: _____

PRESBYTERIAN

Healthplex
Gym Rules

- **All members must badge in before using the Healthplex, and wear his/her name badge at all times while in the facility.**
- **Every member, without exception, needs to be screened by an Exercise Staff Member before his/her first exercise session.**
- **Shoes need to enclose the foot. No dress shoes on wood floors.**
- **Wipe down equipment after use.**
- **Turn towels in after use each day.**
- **Ask for help if you are unfamiliar with any exercise equipment.**
- **Secure your valuables in the locker room. You will need to provide your own lock.**
- **No food or drink in the exercise area, with the exception of water bottles.**
- **Limit yourself to 30 minutes on any piece of exercise equipment.**
- **The gym equipment is reserved exclusively for Cardiac and Pulmonary Rehab participants 22.5 hours a week:**

  Pulmonary/Cardiac Rehab M-W-F 10:00am-5:00 p.m.

- **Children are allowed in waiting areas with adult supervision.**

We reserve the right to prohibit any person from exercising. We may require a signed referral from a physician and concurrence with our clinical staff to exercise.

My signature verifies that I have received the above instructions and agree to abide by them.

_____ _____

Signature **Date**

PRESBYTERIAN

Presbyterian Healthplex
EMPLOYEE PROGRAM
Participant Agreement

Name of Participant: _____

I have enrolled to participate in the Presbyterian Exercise Program. The Program, including its anticipated benefits and risks, has been fully explained to me. I have been informed about the advisability of discussing the risks and benefits of participation with my physician and agree to request additional clarification and/or follow-up with my physician as may be necessary.

I agree to comply with all the rules and regulations of the Exercise Program and to accept full responsibility for my actions and any injuries that may result from my participation in the Program at the Presbyterian Healthplex.

I realize that there are certain associated risks with exercise that may occur during my physical activity regiment. I also realize that I will be able to ask questions and seek advice from staff at the Healthplex regarding my exercise prescription and behavior change strategy towards enhancing my health at the Presbyterian Healthplex.

I hereby release Presbyterian Healthcare Services, its officers, directors, employees and agents from any and all claims, demands, damages or liabilities in any way arising from or related to my participation in the Program.

I have read the foregoing and I understand it. Any questions that I raised have been answered to my satisfaction.

_____ _____

Date **Signature**

_____ _____

Date **Witness**