Membership

Plaza Fitness

Three Stamford Plaza, 5th floor

203-325-9711 INFO@FITWELLGROUP.COM

REGISTRATION INSTRUCTIONS

YOU MAY REGISTER FOR MEMBERSHIP BY COMPLETING THE FOLLOWING REGISTRATION FORMS.

CLUB HOURS: MONDAY – FRIDAY 6AM –9AM; 10:30 - 7:30PM 203-325-9711.

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ADDITIONAL INSTRUCTIONS

1. COMPLETE (BOTTOM OF THIS PAGE)

2. FILL OUT THE PRE-EXERCISE SCREENING QUESTIONAIRE (FOLLOWING PAGES). RETURN FORMS ALONG WITH PAYMENT TO:

PLAZA FITNESS. 301 TRESSER BOULEVARD. FIFTH FLOOR. STAMFORD. CT. 06901

3. MEMBERSHIP ACCESS WILL BE ISSUED UPON COMPLETION OF REGISTRATION.

4. PRIOR TO YOUR FIRST WORK-OUT, WE ASK THAT YOU SCHEDULE 10 MINUTES <u>CLUB SAFETY AND ETIQUETTE.</u> ORIENTATION CLASS IS RECOMMENDED FOR ALL NEW MEMBERS (REFER TO FITNESS SCHEDULE)

MEMBERSHIP FEES PAYABLE ONLY BY CHECK TO: *<u>THREESTAMFORDPLAZA OWNERS.</u>*

ANNUAL MEMBERSHIP: $550.00
QUARTERY MEMBERSHIP: $175.00

LOCKER AND LAUNDRY SERVICE: $375.00 ANNUAL
$250.00 ANNUAL FOR LOCKER ONLY

NAME…………………………………………………………………………………………

COMPANY…………………………………………………………………………………….

LOCATION/MAILING ADDRESS…………………………………………………………

PHONE: OFFICE…………………….HOME………………………. Email:……………………………….

Plaza Fitness Membership Application

PRE-EXERCISE SCREENING QUESTIONAIRE
Today's Date__________

NAME (LAST)____________________ (FIRST__________________ (MI)_______

MAILING ADDRESS________________________________ COMPANY_____________

TELEPHONE: (HOME)__________________ (WORK)___________________ EXT.________

EMAIL:____

DATE OF BIRTH:__________________ AGE_______ GENDER: MALE___ FEMALE_____

Health Status: Do you consider your Health to be EXCELLENT__VERY GOOD__GOOD__FAIR__POOR__?

Does Your Company Subsidize your Membership ___yes___no

If yes, what percent: ___100%___75%___50%___25%___other

Is your company flexible about the time and day you exercise ___yes___no

GENERAL MEDICAL INFORMATION:

Height: _____ft.______ins. Weight:________lbs Desired Weight:_________lbs

Physician:___________________________________Specialty:___________________

Address:____

Phone: ( ) ___________________________ Date of last checkup:________________

Most recent blood pressure measurement:_____/______ (Date:_____/_____/_____)
Resting Heart Rate _____bpm
Have you ever had a stress test? _______yes ________no __________Don't know
If yes, date:___________
If yes, were the results: ______Normal _____Abnormal______Don't know
Blood Pressure Response to exercise: _____Normal _____Abnormal

Are you currently under a doctor's care? ______________Yes ___________No
If yes, explain:____

Do you take any medications on a regular basis? ___________Yes___________No
If yes, please indicate list of medications and REASONS FOR TAKING:
___________________________ - ___________________________
___________________________ - ___________________________
___________________________ - ___________________________
Serious illnesses and dates:____

Past hospitalization and dates:____
Reason:____
In case of EMERGENCY, contact:

Name:_________________________ Relationship_____________ Phone_____________
Name:_________________________ Relationship_____________ Phone_____________

Please check yes or no, if you have ever been told you have a personal history of any of the following conditions. If you answer yes to any of those with an asterick, please answer the appropriate section(s) on the following pages.

YES NO

____ ___ Heart disease:__heart attack __bypass __cardiac surgery __artery disease
____ ____Congenital heart disease
____ ____Rheumatic heart disease
____ ____Heart Murmur*
____ ____Chest pain/pressure/tightness/heaviness:* ____with exertion ___at rest
____ ____Abnormal Resting Electrocardiogram*
____ ____Abnormal blood pressure response to exercise
____ ____High blood pressure (___/____mmHg)
____ ____Elevated triglycerides (___/___mg/dl) present #s
____ ____Stroke (if yes, date ___/___/___)
____ ____Smoke cigarettes? Number per day: ___1-9 ___10-19___20-39___40+
____ ____Smoke ___cigars ___pipes Number per day:________
____ ____Diabetes*
____ ____ Diagnosed hypoglycemia
____ ____ Anemia
____ ____ Other metabolic disease.* ___thyroid ______liver ____kidney ____other
____ ____ Epilepsy
____ ____ Arthritis*
____ ____ Pain or injury.* ____muscle ___joint
____ ____ Back pain or injury.* ___upper back ___middle back ____ lower back
____ ____ Lightheadedness/fainting (whichever applies)*
____ ____ Asthma
____ ____ Obesity
____ _____Pregnant (if yes, dates:_______________________________)
____ _____Unaccustomed shortness of breath with mild exertion
____ _____Labored/discomfort in breathing while laying on back and/or during sleep
____ _____Excessive swelling/fluid retention in ankles
____ _____Severe pain/cramping in calf muscles while walking, yet subsides with rest

Family History: (grandparents, parents, aunts, uncles, siblings)

YES	NO		Family Member	Age of Onset
___	____	Heart disease (circle) heart attack bypass, cardiac surgery, artery disease	_______________	_____________
____	____	Congenital heart disease	_______________	____________
____	____	Stroke	_______________	____________
____	____	High blood pressure	_______________	____________
____	____	Elevated cholesterol levels	_______________	____________
____	____	Elevated triglyceride levels	_______________	____________
____	____	Diabetes	_______________	____________
____	____	Obesity	_______________	____________

I attest that the above information is true to the best of my knowledge. I understand that I will be asked to update this form annually.

Signature ___________________________ Date_______ Witness__________ Date______

If you checked yes to conditions with an asterick, please elaborate as much as possible. If you need more space to write, please use the back of this sheet..

1. Heart Murmur
   What is the diagnosis?____
   When was it diagnosed? _____/_____/_____
   Is the condition still present? ___Yes____No
   How was it diagnosed? (Circle)
   listening thru stethoscope echocardiogram other__________
   Have you been restricted or limited in any way by your doctor?
   ___Yes ____No If yes, please explain______________________________
2. Chest Pain/Pressure/Tightness/Heaviness
   Further explanation____
3. Irregular Heartbeat
   Explain____
4. Abnormal resting Electrocardiogram
   What were the abnormalities? ____
5. Diabetes
   Do you take insulin shots?____________________________ _________________
   Is it controlled by diet?____
   Is it controlled by medication?____
   Any other important information?____
6. Any metabolic disease?
   When were you diagnosed?___/___/___
   Is the condition still present?____
   Any restrictions/limitations?____
7. Arthritis
   Where is it located?___________________________________
   Has it been diagnosed by a doctor ?____
   Are you restricted/limited in any way ?________________________
   Are there certain activities which aggravate the condition?__________________________________
   ____
8. Joint or muscle pain/injury
   Which joint______________________ Which muscle__________________________
   When and how did injury occur?____
   What type of doctor was seen (circle)
   general practitioner orthopedist physical therapist other__________________
   What was the diagnosis?____
   Are you still in treatment?____
   Any restrictions/limitations?
9. Back pain or injury
   Describe pain____
   What type of doctor was seen? (circle)
   general practitioner chiropractor orthopedist other______
   What was the diagnosis? (circle)
   Muscular disc soft tissue other____
   Are you still in treatment?__________________________________
   Any restrictions/limitations?_______________________________________
10. Lightheadedness or fainting?
    What is the cause?____
    Have you seen a doctor?____
    How long have you had this condition?______________________________
    How often do episodes occur?______________________________________
    Any additional comments:____

If needed, can we call your physician for more information?

_____ Yes, I give you my approval to contact my physician.

_____ No, I'd like to speak with you prior to contacting my physician.