

OFFICE USE ONLY			Completed:
FA	FC	PT	<input type="checkbox"/>
Date _____			Initials _____
Time _____			

CANCELLATION POLICY:

It is my responsibility to contact the Wellness Center if I am unable to make my scheduled appointment. **Canceling my appointment with under 24-hour notice will result in a 2-week delay in scheduling** my next appointment. **A missed appointment with no call will result in a 3-week delay in scheduling** my next appointment. If I miss two scheduled appointments, I will not be able to sign up for another one for the remainder of the semester. Campus Recreation is proud to offer this service to students, faculty, staff and alumni. Please value your scheduled appointment and show up in a timely manner.

Signature _____

Please respond as accurately as possible; the below information will be used to ensure a safe exercise environment. All information will remain confidential unless further professional consultation seems warranted.

Name _____ ID # _____ Date _____

Local Home Address _____ Primary Phone _____

City _____ State _____ Zip _____ Alternate Phone _____

Date of Birth ____/____/____ Age ____ Sex M F Email _____

Status: Student Staff Faculty Alumni Family Other: _____

Year in School: Fresh Soph Junior Senior Grad Major: _____

How did you hear about this program?

Flyer Website Class Friend Tour Other: _____

If part of a class assignment: Assignment Due Date: _____ Instructor: _____

I would prefer to receive a reminder via Email Text (phone carrier _____) (Standard text rates apply)

Emergency Contact _____ Phone _____

Relationship to you _____ Address _____

Smoking/Tobacco/Vaping Usage: Never used Smoke only on occasion Smoke up to ____ (#) (pack)/day

Use different form of tobacco (cigar) (pipe) (chew) (other) Ex-Smoker (how long _____)

Alcohol Consumption: Never drink drink only on occasion _____ average drinks per week

Caffeine Consumption: Do not consume caffeinated beverages only on occasion _____ average drinks per week

How long has it been since your last physical examination?

Less than 1 year 1-2 years 2-3 years 3 or more years

Do you have a personal physician? Yes No*

Personal Physician _____ Physician's Phone _____

Physician's Address _____

Do you have medical alert identification? Yes No *If yes, where is it located?* _____

If you do not have a current physician, Health Services can provide you with a physical at a cost of \$40.

How often would you characterize your stress level as being high? Occasionally Frequently Constantly

Please list all medications that you are currently taking.

Name of Drug	Dosage/Frequency	Reason for Taking
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please indicate if you have had, or presently have, any of the following:

- | | | |
|---|--|--|
| <input type="checkbox"/> Thyroid disorder | <input type="checkbox"/> Dizziness or fainting | <input type="checkbox"/> Hernia |
| <input type="checkbox"/> Ankle swelling | <input type="checkbox"/> Unusual shortness of breath | <input type="checkbox"/> Back trouble |
| <input type="checkbox"/> Epilepsy or seizures | <input type="checkbox"/> Recent hospitalization | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Chronic Bronchitis | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Heart attack/heart disease | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Bone or joint problems |
| <input type="checkbox"/> Heart surgery | <input type="checkbox"/> Asthma | <input type="checkbox"/> Low blood pressure |
| <input type="checkbox"/> Heart failure | <input type="checkbox"/> Exercise-induced asthma | <input type="checkbox"/> Hypoglycemia |
| <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Hay fever/other allergies |
| <input type="checkbox"/> Heart valve disease | <input type="checkbox"/> Obesity | <input type="checkbox"/> Emotional disorder |
| <input type="checkbox"/> Heart palpitations | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Eating disorder |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> High blood cholesterol | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High blood triglycerides | <input type="checkbox"/> Phlebitis |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Glucose intolerance | <input type="checkbox"/> Other: _____ |

Are you, or may you be pregnant? Yes No

Describe any surgery that you have had within the last two years _____

Have you ever sustained any injury or experienced any type of chronic pain, which has been diagnosed as due to physical activity or sports participation? Yes No If Yes, please explain _____

Has your weight fluctuated more than a few pounds? Yes No If Yes, please explain _____

Have any members of your immediate (genetic) family been diagnosed with the following:

	Mother	Father	Sister(s)	Brother(s)	Grandparent(s)
Heart disease	_____	_____	_____	_____	_____
Heart attack (under age 50)	_____	_____	_____	_____	_____
Heart surgery	_____	_____	_____	_____	_____
Stroke (under age 50)	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____
Pulmonary disease	_____	_____	_____	_____	_____
Sudden death	_____	_____	_____	_____	_____
High blood pressure	_____	_____	_____	_____	_____
High cholesterol	_____	_____	_____	_____	_____
Obesity	_____	_____	_____	_____	_____
Other: _____	_____	_____	_____	_____	_____

I hereby state that all of the above information is accurate to the best of my knowledge.

Signature _____

Date _____

EXERCISE STATUS

Level of physical activity? Inactive Low (<150 min*) Medium (150-300 min*) High (>300 min*)

*number of minutes of moderate (raised heart rate) intensity activity per week

How often do you perform cardiovascular exercise for at least 20-30 minutes per session?

No regular program 1 time/week 2 times/week 3-4 times/week 5 + times/week

How often do you weight train?

No regular program 1 time/week 2 times/week 3-4 times/week 5 + times/week

Briefly describe your exercise program _____

HEALTH GOALS

Please indicate your *top three* goals.

<input type="checkbox"/> Improve strength	<input type="checkbox"/> Reduce cholesterol	<input type="checkbox"/> Lose weight/decrease body fat
<input type="checkbox"/> Improve muscle tone & shape	<input type="checkbox"/> Reduce blood pressure	<input type="checkbox"/> Gain weight
<input type="checkbox"/> Improve cardiovascular fitness	<input type="checkbox"/> Increase energy	<input type="checkbox"/> Improve diet/eating habits
<input type="checkbox"/> Improve flexibility	<input type="checkbox"/> Reduce stress	<input type="checkbox"/> Train for a sports-specific event
<input type="checkbox"/> Improve health	<input type="checkbox"/> Prevent injury	<input type="checkbox"/> Rehabilitate injury
<input type="checkbox"/> Other _____		

NUTRITION LIFESTYLE

What is your current weight? _____ lb height? ____ ft. ____ in.

What would you like to weigh? _____ lb

What is the most you ever weighed as an adult? _____ lb What is the least? _____ lb

What weight loss methods have you tried? _____

Which do you eat regularly?

Breakfast Midmorning snack Lunch Afternoon snack Dinner After-dinner snack

How often do you eat out each week? _____ times

What size portions do you normally have? Small Moderate Large Extra-large Uncertain

How long does it usually take you to eat a meal? _____ minutes

Do you eat while doing other activities (e.g., watching TV, reading, working)? _____

Consent for Limited Release of Information

Campus Recreation may need to communicate with other SIUE offices on your behalf. Please initial before each of the following if you consent to the exchange of limited information. If you do not wish for any of your information to be shared, do not initial.

____ SIUE Health Service

____ Disability Support Services

____ Counseling Services

____ International Student Services

____ Intercollegiate Athletics

____ Mandating Official (please specify) _____

____ Other (please specify name) _____

You will need to sign a Release of Information Form if you wish to have additional information communicated.

Availability

Services are offered **Monday through Friday, 8:30am – 5:00pm**
Fitness Assessments usually take 30 – 60 min

Please fill out the chart below with at least two available time frames.

We will be able to accommodate you within the following two weeks.

	Monday	Tuesday	Wednesday	Thursday	Friday
Availability (8:30am – 5:00pm)					