



FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

You Got This! Your Y Customized Workout Plan Questionnaire

Client's Name: _____ Date: _____

1. How many days per week are you looking to workout? And approximately how long?
2. What are some of your short-term goals? 3 - 6 months?
3. What are some of your long-term goals? 6 months – 1 year?

4. What is your familiarity with free weights?

With our circuit equipment?

With our cardio machines?

5. Use the following scale to rate each goal separately:

Extremely Important Somewhat Important Not Important
1 2 3 4 5 6 7 8 9 10

Improve Cardio Fitness ____

Body fat/weight loss ____

Improve Sport Performance ____

Stress Reliever ____

Increase Flexibility ____

Increase/improve strength ____

Increase energy levels ____

Feel Better ____

Basic Equipment Knowledge ____

Other (Please be specific) ____

6. Are there any extenuating health issues that we should know about – cardiac, pulmonary, or orthopedic?

7. What are some of your other interests? Hobbies?

THE BANGOR REGION YMCA

17 Second Street, Bangor ME 04401

P 207 941 2808 F 207 941 2812 www.BangorY.org



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The Bangor Region YMCA Health Information Form

The information requested below is necessary in order to provide each member with a safe and appropriate exercise experience. All information will be kept strictly **confidential**.

Name: (Last) _____ (First) _____ (MI) _____ Today's Date _____
Daytime Phone: _____ Home Phone: _____
Address: _____ City: _____ Zip: _____
Email Address: _____ Gender: Male ___ Female ___
Date of Birth: _____ Age: _____ Height ___ ft ___ inches
Weight: _____

General Medical Information

Date of Last Checkup: _____
Are you currently under a doctor's care? Yes ___ No ___ If yes, explain:

Please list all physicians you are currently under the care of:

Physician: _____ Specialty: _____
Address: _____
Phone: _____

Most Recent Blood Pressure Reading: _____ / _____ Date: _____

Do you currently exercise? Yes ___ No ___ If yes, please list activities and other recreational pursuits:

Would you like more information about:

- ___ Orientation
- ___ Personalized Exercise Program
- ___ Personal Training
- ___ Personal Training in the pool
- ___ Biggest Mover

Do you accumulate 30 minutes or more of moderate physical activity on most days of the week? Y ___ N ___
Does your job require you to sit or stand in one place for the majority of the time? Y ___ N ___

Have you ever had a stress test? Yes ___ (If yes, date: ___/___/___) No ___ Don't know ___
If yes, were the results: Normal ___ Abnormal ___ Don't know ___
Blood pressure response to exercise: Normal ___ Abnormal ___ Don't know ___

Do you take any medications on a regular basis? Yes ___ No ___
If yes, please list medications, dosage, and REASON FOR TAKING

If needed, can we call your physician for more information (please initial) _____
___ Yes, I give you my approval to contact my physician
___ No, I'd like to speak with you prior to contacting my physician

Office Use Only:

If you have been or are presently being treated for any of the following conditions please check yes or no. If you answer yes to any of those with an asterisk, please answer the appropriate section(s) on the following pages.

YES NO

- Heart disease: (circle) heart attack, bypass, cardiac surgery, artery disease, heart valve problems
- Congenital heart disease
- Rheumatic heart disease
- *Chest, neck, jaw, or arm pain/pressure/tightness/heaviness: with exertion ___ at rest ___
- Abnormal resting Electrocardiogram
- *Heart murmur
- *Irregular heart beat: rapid ___ slow ___ skipped beats ___ extra beats ___
- Stroke (if yes, date: ___/___/___)
- *Diabetes (fasting blood glucose ___mg/dl)
- *Other metabolic disease: thyroid ___ liver ___ kidney ___ other ___
- Epilepsy
- Abnormal blood pressure response to exercise
- High blood pressure (___/___ mm Hg)
- Elevated Cholesterol (>200 total, HDL <35, LDL > 130 or on cholesterol lowering medication):
Total: ___ mg/dl HDL ___ mg/dl LDL ___ mg/dl
- Elevated triglycerides (present # ___/___mg/dl)
- Smoke cigarettes
- Quit smoking within the last 6 months
- Diagnosed hypoglycemia
- Anemia
- Asthma: (if yes, please explain: _____)
- Obesity
- Pregnant (if yes, dates: _____)
- Osteoporosis
- *Arthritis
- *Joint or muscle pain/injury
- *Back pain or injury: upper back ___ middle back ___ lower back ___
- *Lightheadedness ___ or Fainting ___ (whichever applies)
- *Serious Illness
- *Surgery
- *Hospitalization

Family History:

(parents, siblings, or children before 55 years of age for males and before 65 years of age for females)

| YES | NO | Family Member | Age of Onset |
|--------------------------|--------------------------|--|---------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Heart disease (circle) heart attack, bypass surgery, cardiac surgery, artery disease | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Sudden death | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Congenital heart disease | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Stroke | _____ |

I understand that I am participating in an exercise program at my own risk and under the same terms mentioned on the membership form. I attest that I have voluntarily provided information for this form and that it is true to the best of my knowledge. I understand that I am responsible for updating this form annually or as health information changes, whichever comes first. I give employees of the Bangor Region YMCA permission to review my health information provided on this form. I understand that completion of this form does not impose any liability or obligation upon the Bangor Region YMCA.

Signature _____ Date ___/___/___ Witness _____ Date ___/___/___
 Signature of Parent/Guardian if under 18 _____ Date ___/___/___

If you checked yes to conditions with an asterisk (*), please elaborate as much as possible. Please feel free to use the back if necessary.

1. Chest pain/pressure/tightness/heaviness

Explain: _____

2. Heart murmur

What is the diagnosis? _____

When was it diagnosed? ____/____/____

Is the condition still present? Yes ____ No ____

How was it diagnosed? Stethoscope ____ Echocardiogram ____ Other _____

Have you been restricted or limited in any way by your doctor Yes ____ No ____

If yes, explain: _____

3. Irregular heart beat

Explain: _____

4. Diabetes

Do you take insulin shots? _____

Is it controlled by diet? _____

Any restrictions/limitations? _____

Any other important information? _____

Do you take medications? If so, what? _____

5. Metabolic Disease

When were you diagnosed? ____/____/____

Is the condition still present? Yes ____ No ____

Any restrictions/limitations? _____

6. Arthritis

Where is it located? _____

Has it been diagnosed by a doctor? _____

Any restrictions/limitations? _____

Are there certain activities which aggravate the condition? _____

7. Joint or muscle pain/injury

Which joint? _____ Which muscle? _____

When and how did the injury occur? _____

What type of doctor was seen? General Practitioner ___ Orthopedist ___ Physical Therapist ___ Other ___

What was the diagnosis? _____

Are you still in treatment? _____

Any restrictions/limitations? _____

8. Back pain/injury

Describe pain _____

What type of doctor was seen? General Practitioner ___ Orthopedist ___ Physical Therapist ___ Other ___

What was the diagnosis? _____

Are you still in treatment? _____

Any restrictions/limitations? _____

9. Lightheadedness or fainting

What is the cause? _____

Have you seen a doctor? _____

How long have you had this condition? _____

How often do episodes occur? _____

10. Allergies – What are they? _____

Please provide any other details _____

11. Serious Illness

Please describe (what, when): _____

12. Surgery – Please describe (what, when): _____

13. Hospitalization – Please describe (what, when): _____