Fitness Principle Application Form
Section A: Personal Info

Thank you for your interest in our Program. Your application will be evaluated and you will be contacted. All information will be kept confidential.

I. PERSONAL INFORMATION

Applicant's Name			Program Applied For	
Age	Sex	Marital Status	Health	Dominant Side

Address	City	State	Zip

Home Phone	Daytime Phone
Cell Phone	e-mail

Height	Weight	% Body Fat (if known)

II. HEALTH HISTORY

Personal Physician's Name	
Physician's Address	Physician's Phone

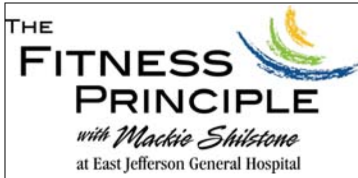
Injury (if any)	Date Injury Occurred	Type

If injured, where and how did injury occur?
Physician's diagnosis of injury
Status of Injury (i.e., surgery/rehab)

If surgery, name of surgeon	Phone
If rehab, name of therapist	Phone

Where was rehab performed?
Any other injuries or non-sports-related health problems?

III. TELL US A LITTLE ABOUT YOURSELF (PRINT IN YOUR OWN HANDWRITING, PLEASE)	
Background (school, hobbies, career objectives)	
Your expectations of the Center	
How did you hear about the Center?	
FOR OFFICE USE ONLY	
Date of Interview	Application Evaluator
Evaluation	



Fitness Principle Application Form
Section B: Medical History

This section of the form should be completed by the applicant, and must be signed by both the applicant and the applicant's physician where indicated.

IV: MEDICAL HISTORY (TO BE COMPLETED BY APPLICANT)

Applicant's Name			
Address	City	State	Zip
Date of Birth	Home Phone	Sports	
SSN#	Employer	Work Phone	
Insurance Company	Policy #	Family Physician	

Please answer the following questions by circling the appropriate response. Use the next page of this form to explain any "Yes" answers to the following questions. Have or do you:

01.	Have a medical problem or injury since your evaluation?	Yes	No
02.	Ever not been allowed to participate in sports for a medical reason?	Yes	No
03.	Ever been hospitalized?	Yes	No
04.	Ever had surgery?	Yes	No
05.	Have any missing organs (i.e., kidney, eye, testicle)?	Yes	No
06.	Presently take any medication?	Yes	No
07.	Have any allergies to medicine or insect bites?	Yes	No
08.	Passed out during or after exercise?	Yes	No
09.	Been dizzy during or after exercise?	Yes	No
10.	Have chest pain during or after exercise?	Yes	No
11.	Tire more quickly than your friends during exercise?	Yes	No
12.	Have high blood pressure?	Yes	No
13.	Been told you have a heart murmur?	Yes	No
14.	Have racing of the heart or skipped heartbeats?	Yes	No
15.	Have a family member that died of heart problems or sudden death before age 50?	Yes	No
16.	Have any skin problems?	Yes	No
17.	Ever had a head or neck injury?	Yes	No
18.	Ever been knocked out or unconscious?	Yes	No
19.	Ever had a seizure?	Yes	No
20.	Ever had a stinger, burner, or pinched nerve?	Yes	No
21.	Ever had heat cramps?	Yes	No
22.	Ever been dizzy or passed out in the heat?	Yes	No
23.	Have trouble with breathing or coughing during or after activity?	Yes	No
24.	Use any special equipment (pads, braces, neck rolls, eye guards, kidney belt, etc.)?	Yes	No
25.	Have any problems with vision?	Yes	No
26.	Wear glasses or contacts?	Yes	No

27.	Ever sprained/strained, dislocated, fractured, or had repeated swelling for any bones or joints?	Yes	No
28.	Have any medical problems listed below? If Yes, please check all that apply	Yes	No

	High Blood Pressure		Rheumatic Fever		Diabetes		Hepatitis
	Abnormal Bleeding		Tuberculosis		Asthma		Mononucleosis
	Other (List)						

Please explain all YES answers from the questions above:

V: HEALTH BEHAVIOR

01.	Do you sometimes feel that if you could only lose weight, you would then be able to achieve most or all of your other goals?	Yes	No
02.	Are you frequently depressed or anxious because you feel fat or overweight?	Yes	No
03.	Do you feel “good” or “bad” according to how much you eat, how much you weigh, or how much exercise you get in?	Yes	No
04.	Are you frightened at the thought of eating situations where you will have to eat a “normal” meal?	Yes	No
05.	Do you frequently eat beyond the point of fullness, to the point of physical discomfort?	Yes	No
06.	When you feel full, do you also feel self-hatred, desperation, panic or depressed?	Yes	No
07.	Do you have a list of “good” foods and “bad” foods?	Yes	No
08.	Do you avoid eating for long periods of time as a way to control your weight?	Yes	No
09.	Do you feel compelled to eat when you are home alone?	Yes	No
10.	Do your eating and weight loss activities interfere with work, school and/or relationships?	Yes	No

11.	Do you feel frightened of food or eating?	Yes	No
12.	Do you get angry at people if they question what or how much you eat?	Yes	No
13.	Do you find you cannot stop thinking about food and/or weight?	Yes	No
14.	Do you blame others for the way you look and feel?	Yes	No
15.	Do you have trouble making decisions?	Yes	No
16.	Do you think that your weight makes you lonely?	Yes	No
17.	Do you eat when you are stressed, angry or sad?	Yes	No
18.	Do you feel like you deserve to look and feel good?	Yes	No
19.	Do you think that if you lose weight people will like you better?	Yes	No
20.	Are you afraid that if you lose weight people will notice you more?	Yes	No

VI: SIGNATURES

You must answer all questions below and sign your name in order to be examined:

01.	The above information is current and correct to the best of my knowledge	Yes	No
02.	If in the judgment of a representative of the Program, I need care or treatment as a result of an injury or sickness, I do hereby request, consent to and authorize such care as may be deemed necessary.	Yes	No
03.	I recognize the evaluation to be done is a standard pre-participation screening examination, and that no in-depth testing, x-rays, lab work, or cardiac test work will be performed.	Yes	No

Applicant's Signature	Date

Return completed application by fax to The Fitness Principle at 504-457-3111. Copies available at www.EJGH.org

Fitness Principle Application Form
Section D: Waiver of Liability

This section of the form should be completed and signed by the applicant, or by the applicant's legal guardian if applicant is under 18 years of age, as well as by the applicant's physician were indicated below.

WAIVE R

____(“Participant”) acknowledges that he/she will be taking part in a program of exercise and athletic training including but not limited to activities of the Fitness Principle and/or The EJGH Wellness Center. The undersigned acknowledges that the participant has undergone a complete medical examination exclusively in anticipation of this program by an independent physician who has determined that the participant is in appropriate medical condition to participate in a program of vigorous exercise and athletic training activities which may include, but are not limited to jumping, running, weight lifting and conditioning and other exercises. It is acknowledged that medical clearance has been obtained specifically for such activities.

The undersigned desires to voluntarily utilize the services and, if applicable, facilities and equipment provided by The Fitness Principle and/or The Wellness Center for the purpose of personal fitness, recreation, or fitness evaluation. As a consideration for the right and privilege of being permitted access to, and the use of, services or programs offered by The Fitness Principle and/or The Wellness Center, and if applicable, facilities and equipment, the undersigned does hereby release The Fitness Principle, EJGH Wellness Center, East Jefferson General Hospital, its officers, agents and employees from any and all liabilities of any kind whatsoever arising out of any physical or mental injury incurred or sustained by the undersigned while at or participating in any of the fitness programs, recreational or evaluation services and facilities and use of equipment provided by The Fitness Principle and/or The Wellness Center; and furthermore, agrees to save and hold harmless The Fitness Principle, EJGH’s Wellness Center, East Jefferson General Hospital, its officers, employees, assigns, rising out of the undersigned’s use of the facilities and/or services.

Furthermore, the undersigned acknowledges that he or she may participate in activities involving physical exertion or exposure to heat or steam. The undersigned acknowledges that he or she has obtained independent medical approval to use the services or programs, and if applicable, facilities and equipment provided by The Fitness Principle and/or The Wellness Center for the undersigned’s participation in activities involving physical exertion and that he has made the Fitness Principle Director aware of any limitations suggested by his/her physicians.

The undersigned acknowledges and affirms that he or she has carefully read this release and has asked and obtained a satisfactory explanation of any part that he or she does not understand.

Applicant's Signature	Date
Signature of parent or legal guardian if applicant is under 18 years of age	Date

PHYSICAN'S STATEMENT

I hereby certify that I examined and found the applicant physically fit to attend and to participate in The Fitness Principle with Mackie Shilstone at East Jefferson General Hospital. I know of no impairments, which would limit participation in program activities. (Please attach any comments).

☐ There are limitations to the applicant’s participation. Please see page 7/7 for details.

Physician’s Signature	Date

THE FITNESS PRINCIPLE with Mackie Shilstone at East Jefferson General Hospital

The Fitness Principle Application Form
Section E: Medical Clearance

This section of the form should be completed by the applicant, and must be signed by both the applicant and the applicant's physician where indicated.

MEDICAL CLEARANCE (TO BE COMPLETED BY APPLICANT)

Please answer the following questions by circling the appropriate response.

01.	Do you have a primary care physician?	Yes	No
	If yes, is your primary care physician at East Jefferson General Hospital?	Yes	No
	Name of Provider:		
02.	Have you had a physical from a health care provider within the past 12 months?	Yes	No
03.	Have you had blood work from a heath care provider within the past 12 months?	Yes	No
04.	Would you like East Jefferson General Hospital to provide your medical clearance to enter into The Fitness Principle with Mackie Shilstone at East Jefferson General Hospital?	Yes	No
	If no, please supply the name of the name of the provider that will provide medical clearance:		
	Name of Provider:		

I understand that there may be diagnostic tests performed that may not be covered by insurance and that I will be responsible for those tests. I understand that if I have had a physical by my health care provider for medical clearance at this time, I will be personally responsible for any services not covered by my insurance.

Applicant's Signature	Date
Signature of parent or legal guardian if applicant is under 18 years of age	Date

Physician Comments:

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________________ Date   ________________ Signature