BodyWorks Health and Lifestyle Form

Full Name (First, Middle, Last): _____ ☐**Male** ☐**Female**

Home Phone: _____ **Work Phone:** _____ **Cell Phone:**_____

Email Address: _____ **Birthdate (month/day/year):**_____

Emergency Contact Name: _____

Phone Number: _____ _____ **Relationship:**_____

Availability for Personal Training Sessions:

Weekdays: ☐ A.M. ☐Noon ☐P.M. **Weekends**: ☐A.M. ☐ Noon ☐ P.M.

Please mark your preference for your Personal Trainer and/or Volunteer: ☐ Male ☐ Female ☐ No Preference

Please check your personal health and fitness objectives:

- □ Lose body fat
- □ Improve posture
- □ Decrease stress
- □ Decrease effects of a chronic disability
- □ Prevent disease risk factors
- □ Maintain independent living
- □ Increase overall strength
- □ Increase flexibility
- □ Improve performance in: _____ _____

□ Other: _____

Have you had or do you presently have any of the following? Please check all that apply.

Condition	Now	Past
Cardiovascular Condition. If yes, please list:		
Heart Attack (MI)		
Revascularization		
Stroke		
Heart Surgery		
Angina		
Fainting/Dizziness		
Hypertension		
Hypotension		

Condition	Now	Past
Prediabetes		
Diabetes (Type I)		
Diabetes (Type II)		
Dyslipdemia		
Obesity		
Physical Inactivity		
Allergies		
Epilepsy (Seizure)		
Hernia		
Anxiety		

Condition	Now	Past
Depression		
Osteoporosis		
Osteopenia		
Asthma		
Ankle swelling		
COPD		
Cancer		
Other (please list)		

(Please flip page over)

How many minutes per week do you perform physical activity where you experience an elevated rate of breathing? _____

Do you currently use an assistive device for walking? ☐ Yes ☐ No ☐ Sometimes

If so, please indicate the type of device you use: ☐ Cane ☐ Quad Walker ☐ Rolling Stand Walker

Can you do heavy household chores? ☐ I can ☐ I can't ☐ I can with difficulty

Please list all medication(s) that you are currently taking: _____
_____

	Yes	No	Sometimes
Do you experience headaches?			
Do you feel you have any vision problems?			
Are you confident venturing outside your house?			
Are you worried about falling?			
Do you have difficulty sleeping?			
Do you currently smoke?			
Did you smoke within the last six (6) months?			
Has anyone in your immediate family (mother, father, sibling) suffered a cardiac episode?			
Do you consider your diet to be balanced?			
Do you feel your mental health will impact your ability to be successful in physical activity?			
Do you have any bone or muscle injuries that may interfere with physical activity? If so, please list: _____			

Your personal information is collected under the authority of section 26(c) of the *Freedom of Information and Privacy Act* (FIPPA). This information will be used for the purpose of evaluating your application for admission to the UBC BodyWorks Fitness Centre. Questions about the collection of this information may be directed to kin.outreach@ubc.ca.