CEMR
CENTER *for* EXERCISE MEDICINE & REHABILITATION
VALDOSTA STATE UNIVERSITY

Membership Information

Thank you for your interest in the Center for Exercise Medicine and Rehabilitation, Fitness and Wellness Center!

There are many benefits of regular physical activity that include preventing and managing chronic disease, increasing energy, improving sleep, and weight control - just to name a few!

If you are interested in beginning an exercise program with us, you will be given certain forms to fill out in order to develop a safe and effective exercise program. All new members are required to have an initial health assessment and orientation to the fitness center to ensure the safety of the participant.

We are located on Valdosta State University's beautiful north campus in the Health Sciences and Business Administration building, first floor. If you would like more information on membership opportunities, pricing and policies, or services offered please visit our website or contact us!

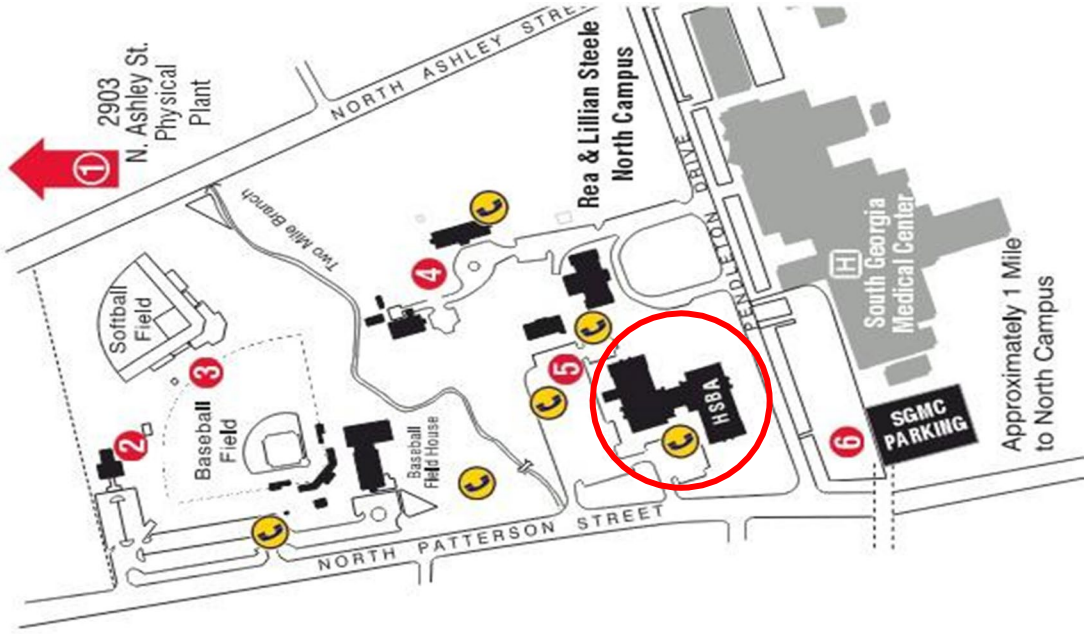
We look forward to hearing from you!

Contact Us!
Phone: 229-253-2887
Fax: 229-219-1284
Email: cemr@valdosta.edu

Facility

The Center for Exercise Medicine and Rehabilitation is a supervised exercise facility coordinated by the faculty and students of the Exercise Physiology program at Valdosta State. Located conveniently on the first floor of the newly constructed Health Sciences and Business Administration (HSBA) building on VSU's North Campus, this health facility works closely with South Georgia Medical Center to provide the full spectrum of care for its clients.

Campus Address
Health Sciences and Business Administration Building
2525 North Patterson St.
Valdosta, Georgia 31698
First Floor, Room 1054



****For parking restrictions, see "General Information"****

Contact Us!

Phone: 229-253-2887

Fax: 229-219-1284

Email: cemr@valdosta.edu

Benefits

The Center for Exercise Medicine and Rehabilitation:

- Ensures continuous supervision by well-trained, knowledgeable staff
- Promotes a safe and healthy fitness environment
- Administers individualized exercise prescriptions
- Offers online diet, activity, and overall wellness tracking through WellSource®
- Is conveniently located on Valdosta State's North Campus
- Provides clean and private restroom and shower facilities

When considering health benefits, exercise can:

- Lower blood pressure and cholesterol
- Strengthen the heart and improves blood circulation
- Lower the risk of heart disease and stroke
- Strengthen muscles and bones
- Keep joints flexible
- Improve balance to prevent falls
- Burn calories to help decrease/maintain weight
- Increase energy
- Improve sleep
- Relieve stress
- Reduce symptoms of depression
- PLUS MORE!

Why Is Physical Activity Important?

Physical activity and exercise are key components in establishing and maintaining a healthy lifestyle. Walking, jogging, biking, swimming, weight lifting, and sports are just some of the many ways to stay active. When paired with a healthy diet, regular physical activity can promote weight loss or weight maintenance, improve blood pressure measurements, reduce cardiovascular disease risks, increase energy levels, strengthen bones and muscles, and even improve sleep. In younger populations, activity also enables healthy growth and development; while in older adults, it improves balance and the ability to independently perform daily tasks. While physical activity and exercise are generally safe in any stage of life, be sure to consult with your doctor before engaging in a new program.

Services and Rates

The Center for Exercise Medicine and Rehabilitation: Fitness and Wellness Clinic serves VSU faculty and staff as well as members of the community.

CONSIDERATION	SERVICE	PRICE	TIME
Disease Prevention Peripheral Arterial Disease* Diabetes* Coronary Heart Disease* Cancer Survivor Weight Loss	Initial Assessment *Includes:* *Personal Wellness Profile* *Metabolic/Routine Exercise Stress Test* *Muscular Fitness* *Body Composition* *Flexibility*	$150**	By Appt. Only
Metabolic Syndrome* Pediatric Obesity Others as warranted	Monthly Membership	$50	20-60 Minute Sessions Exercise time may be assigned

*Physician Referral
**Includes first month membership. Additional charges will apply for extra assessments as requested.

Advance payment of 6 month membership with complete assessment = $375.00 *All program fees are non-refundable.*

Those who consistently adhere (3 days/week average) to the exercise prescription will be entitled to complete retesting after 6 months.

Additional testing is available through the Valdosta State Human Performance Lab**

General Information

Hours of Operation: All hours subject to change depending on class schedules and semester. Summer hours may vary. The fitness center will be closed during VSU observed holidays and academic breaks.

Monday – Thursday	Friday	Saturday & Sunday
7:00 AM – 7:00 PM	*7:00 AM – 5:00 PM*	*Closed*

Equipment: Our facility provides a variety of Technogym® equipment to meet the various needs of our members! *For more information on facility amenities, click here!*

What to Wear: Clothing should be family-friendly, comfortable, safe, and appropriate for your activity. For safety reasons, closed-toe shoes must be worn in the facility.

Parking: Parking spots labeled "Clinic Parking"are available to members in the general parking area located at the HSBA building. Additional parking is provided across the street in the SGMC visitor's parking lot and at the nearby walking track at Valdosta Middle School.

Shower Rooms: Shower rooms for both men and women are located in the HSBA building across the hall from the fitness facility.

Towels: Exercise and shower towels are provided, free of charge, to all members.

Safety: Exercise Physiology students may be present to assist in assessment and training of our members. All of our employees and students are certified in Basic Life Support (BLS) through the American Heart Association (AHA).

Health Status Change: Any change in medication, surgical status, or general health should be reported to fitness center personnel. Physician clearance may also be required.

Key Replacement: A $50 fee will be charged for the replacement of member keys.

Emergency Procedures: In the case of an emergency, notify the nearest staff member. A first aid kit, CPR mask, and AED are available. If necessary, fitness personnel will contact Emergency Medical Services (EMS).

Member Application and Agreement

Date: _____

Member Information:

Name _____ _____ _____ Date of Birth: _____

Last First MI

Address: _____

Number and Street City State Zip

Home Phone: _____ Mobile Phone: _____ Work Phone: _____

Email: _____

Occupation: _____ Employer: _____

Business Address: _____

Number and Street City State Zip

Emergency Contact:

Name: _____ Relationship: _____

Daytime Phone: _____ Evening Phone: _____

VSU EMPLOYEES ONLY

Membership Type:

_____ 10 month employee _____ 12 month employee

Fees and Dues:

Assessment Fee: To assess cardiovascular disease risk and fitness, member agrees to pay $_____. Assessment fee includes first month membership. Assessment fees are nonrefundable.

Monthly dues for membership selected are $_____ per month. Monthly dues for the following month, along with authorized member charges will be collected no later than the 5th/20th of the month, unless previously paid by other means. All members must provide the information required below.

Payment Summary:

Total Assessment Fee $_____ Total Payment upon Enrollment $_____

Monthly Dues $_____ Payment Method: _____ Cash _____ Check _____Credit Card

Member Dues:

1. **"Freezing" Memberships:** Freezing of memberships is not permitted except when the member is not able to exercise due to illness or injury. In that instance, time will be credited in monthly increments. A physician's note is required to freeze the membership, one week in advance, before the first day of the month, which membership will be frozen. A physician's note is also required to restart the exercise program after illness or injury.
2. **Canceling Memberships:** Payroll deductions will remain in full force and effect until the member has provided the fitness center written notification, one week in advance, before the first day of the month, of your intention to cancel your privileges. Notification of cancellation may be brought in person, faxed to (229) 219-1284 with Attn: CEMR - Fitness & Wellness Center, or sent by mail to: CEMR - Fitness & Wellness Center, Valdosta State University, College of Nursing and Health Sciences, 1500 North Patterson Street, Valdosta, GA 31698.
3. **Transfer of Memberships:** Transferring a membership to another individual is not permitted.
4. **Refunds:** Members who are unable to use the facility or choose to cancel membership will not be granted a refund for months already paid. Members may freeze or cancel the membership with a written request, as stated above.
5. **Service Charge:** a $25 service fee will be charged on all returned checks, overdrafts, and invalid credit cards.
6. **Unpaid Balances:** All balances which are 30 days past due are subject to a $25 monthly service fee. Management reserves the right to collect the current and past due balance and/or suspend and/or terminate membership privileges.

Suspension/Termination of Membership by Management:

Management has the right to suspend and/or terminate any membership for non-payment of dues, fees, or for behavior inimical to the enjoyment of the Center for Exercise Medicine and Rehabilitation by other members and by staff for any reason deemed sufficient in the sole discretion of management.

Buyer's Right to Cancel or Terminate:

Members have the right to cancel this contract within three (3) business days after the receipt of a copy of this contract. Cancellation must be in writing and delivered to the Center for Exercise Medicine and Rehabilitation either in person, by fax, or by certified registered mail. All faxed and mailed cancellations will be dated 30 days from fax date to postmark. Dues for the final month will be prorated and billed during the final month. Month-to-month members may voluntarily terminate membership at any time after their 10 month or 12 month agreement for any reason by: 1) notifying the center in writing by fax, certified mail, return receipt requested, or in person 30 days prior to cancellation and 2) paying all charges prior to termination. The Center for Exercise Medicine and Rehabilitation fees are non-refundable except as indicated above.

Rules and Regulations:

1. Late Policy: In order to give proper attention to all clients, appointments will be canceled if client is more than 15 minutes late.
2. Cancellation/Rescheduling: Clients are encouraged to cancel or re-schedule appointments at least 48 hours in advance unless special circumstances exist.
3. No-Show Policy: Clients who miss more than one appointment without notification will lose appointment time priority.
4. Members are responsible for securing personal belongings. The Center for Exercise Medicine and Rehabilitation and its staff assume no responsibility for lost or damaged personal items.
5. To ensure the safety of all our members and visitors, children under 16 years of age may not be left unattended.
6. The use and/or consumption of tobacco, alcohol, and other substances are prohibited in the fitness center.
7. All members understand and agree that the Center for Exercise Medicine and Rehabilitation personnel will guide and control the fitness facility environment. It is expected that members behave in a quiet, well-mannered fashion while in the facility and any major criticisms regarding other members will be relayed only to fitness center staff in the privacy of the management office. At the manager's discretion, memberships can be terminated if behavior is deemed unsatisfactory.

Acceptance and Agreement:

I hereby agree to accept and abide by the terms of this Membership Application and Agreement. I understand that this membership agreement is for a term of 10 months or 12 months and will continue unless canceled by me in writing. **Initial _____**

_____ _____

Member Signature Date

_____ _____

Accepted by Date

Wellness and Fitness
AGREEMENT AND RELEASE OF LIABILITY

1. In consideration of gaining membership or being allowed to participate in the activities and programs of *Valdosta State University - Exercise Physiology* and to use its facilities, equipment, and machinery in addition to the payment of any fee or charge, I do hereby waive, release and forever discharge The Board of Regents of the University System of Georgia by and on behalf of *Valdosta State University* and it officers, agents, employees, representatives, executors, and all others from any and all responsibilities or liability for injuries or damages resulting from my participation in any activities or my use of equipment or machinery in the above-mentioned facilities or arising out of my participation in any activities at said facility. I do also hereby release all of those mentioned and any others acting upon their behalf from any responsibility or liability for any injury or damage to myself, including those caused by the negligent act or omission of any of those mentioned or others acting on their behalf or in any way arising out of or connected with my participation in any activities of *Valdosta State University - Exercise Physiology* or the use of any equipment at *Valdosta State University - Exercise Physiology*. (**Please initial** _____)

2. I understand and am aware that strength, flexibility, and aerobic exercise, including the use of equipment, are potentially hazardous activities. I also understand that fitness activities involve a risk of injury and even death and that I am voluntarily participating in these activities and using equipment and machinery with knowledge of the dangers involved. I hereby agree to expressly assume and accept any and all risks of injury or death. (**Please initial** _____)

3. I do hereby declare myself to be physically sound and suffering from no condition, impairment, disease, infirmity, or other illness that would prevent my participation in any of the activities and programs of *Valdosta State University - Exercise Physiology* or use of equipment or machinery except as hereinafter stated. I do hereby acknowledge that I have been informed of the need for a physician's approval for my participation in an exercise/fitness activity or in the use of exercise equipment and machinery. I also acknowledge that it has been recommended that I have a yearly or more frequent physical examination and consultation with my physician as to physical activity, exercise, and use of exercise and training equipment so that I might have recommendations concerning these fitness activities and equipment use. I acknowledge that I have either had a physical examination and have been given physician's permission to participate, or that I have decided to participate in activity and/or use of equipment and machinery without the approval of my physician and do hereby assume all responsibility for my participation and activities, and utilization of equipment and machinery in my activities. (**Please initial** _____)

Date: _____ Signature: _____

American College of Sports Medicine (2012). *ACSM's Health/Fitness Facility Standards and Guidelines*, 4th edition. Human Kinetics; Champaign, IL

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Wellness and Fitness

INFORMED CONSENT FOR PARTICIPATION IN AN EXERCISE PROGRAM

1. PURPOSE AND EXPLANATION OF PROCEDURE

I hereby consent to voluntarily engage in an acceptable plan of exercise conditioning. I also give consent to be placed in program activities that are recommended to me for improvement of my general health and well-being. These may include dietary counseling, stress reduction, and health education activities. The levels of exercise I will perform will be based upon my cardiorespiratory (heart and lung) fitness as determined through my recent laboratory graded exercise evaluation. I will be given exact instructions regarding the mount and kind of exercise I should do. I agree to participate 3 times per week in the formal program sessions. Professionally trained personnel will provide leadership to direct my activities, monitor my performance, and otherwise evaluate my effort. Depending upon my health status, I may or may not be required to have my blood pressure and heart rate evaluated during these sessions to regulate my exercise within the desired limits. I understand that I am expected to attend every session and to follow staff instructions with regard to exercise, diet, stress management, and smoking cessation. If I am taking prescribed medications, I have already so informed the program staff and further agree to so inform them promptly of any changes my doctor or I make with regard to use of these. I will be given the opportunity for periodic assessment with laboratory evaluations every 6 months after the start of my program. Should I remain in the program thereafter; additional evaluations will generally be given at 12 month intervals. The program may change the foregoing schedule of evaluations, if this is considered desirable for health reasons.

I have been informed that during my participation in exercise, I will be asked to complete physical activities unless symptoms such as fatigue, shortness of breath, chest discomfort, or similar occurrences appear. At that point, I have been advised it is my complete right to decrease or stop exercise and that it is my obligation to inform the program personnel of my symptoms. I hereby state that I have been so advised and agree to inform the program personnel of my symptoms, should any develop.

I understand that, while I exercise, a trained observer will periodically monitor my performance and perhaps measure my pulse and blood pressure or assess my feelings of effort for the purposes of monitoring my progress. I also understand that the observer may reduce or stop my exercise program, when any of these findings so indicate that this should be done for my safety or benefit.

2. RISKS

I understand and have been informed that there exists the remote possibility during exercise of adverse changes including abnormal blood pressure, fainting, disorders of heart rhythm, and very rare instances of heart attack or even death. I have been told that every effort will be made to minimize these occurrences by proper staff assessment of my condition before each exercise session, by staff supervision during exercise, and by m own careful control of exercise efforts. I have also been informed that emergency equipment and personnel are readily available to deal with unusual situations should these occur. I understand that there is a risk of injury, heart attack, or even death as a result of my exercise, but knowing those risks, I desire to participate as herein indicated.

3. BENEFITS TO BE EXPECTED AND ALTERNATIVES AVAILABLE TO EXERCISE
I understand that this program may or may not benefit my physical fitness or general health. I recognize that involvement in the exercise sessions will allow me to learn proper ways to perform conditioning exercises, use of equipment, and regulate physical effort. These experiences should benefit me by indicating how my physical limitations may affect my ability to perform various physical activities. I further understand that if I closely follow the program instructions, I will likely improve my exercise capacity after a period of 3 to 6 months.

4. CONFIDENTIALITY AND USE OF INFORMATION
I have been informed that the information obtained in this exercise program will to the extent of applicable federal and Georgia state laws, be treated as privileged and confidential and will consequently not be released or revealed to any person without my express written consent. I do, however, agree to the use of any information that is not personally identifiable with me for research and statistical purposes so long as it does not identify me or provide facts that could lead to my identification. Any other information obtained, however, will be used only by the program staff in the course of prescribing exercise for me and evaluating my progress in the program.

5. INQUIRIES AND FREEDOM OF CONSENT
I have been given an opportunity to ask certain questions as to the procedures of this program. Generally, these requests have been noted by the interviewing staff member, and his/her responses are as follows.

I further understand that there are also other remote risks that may be associated with this program. Despite the fact that a complete accounting of all these remote risks has not been provided to me, I still desire to participate.

I acknowledge that I have read this document in its entirety or that it has been read to me if I have been unable to read same.

I consent to the rendition of all services and procedures as explained herein by all program personnel.

Date _____

_____
Participant's Signature

_____
Witness' Signature

American College of Sports Medicine (2012). *ACSM's Health/Fitness Facility Standards and Guidelines*, 4th edition. Human Kinetics; Champaign, IL

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Wellness and Fitness
STUDENT INVOLVEMENT

The Center for Exercise Medicine and Rehabilitation serves as a clinical site for the Valdosta State University Exercise Physiology Program. Students may participate in examinations or assessments and in the care of patients/clients as a part of the Valdosta State University Exercise Physiology Program. Student and Patient/Client interactions will follow guidelines set forth by the Valdosta State University Exercise Physiology Program and the Center for Exercise Medicine and Rehabilitation. Students will perform skills only under the supervision of a Certified Exercise Physiologist or Faculty member. Patient/Client care shall always take priority in the Center for Exercise Medicine and Rehabilitation

I have read and understand this policy.

Member Name Signature Date

Thank you for your continued support of VSU and the Center for Exercise Medicine and Rehabilitation!

CEMR
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VALDOSTA STATE UNIVERSITY

Photography Release

I hereby authorize the Center for Exercise Medicine and Rehabilitation, hereafter referred to as CEMR, to publish photographs taken of me for use in the print, online, and video-based marketing materials, as well as other CEMR publications.

I hereby release and hold harmless from any reasonable expectation of privacy or confidentiality with the images specified above.

I further acknowledge that my participation is voluntary and that I will not receive financial compensation of any type associated with the taking or publication of these photographs or participation in CEMR marketing materials or other CEMR publications. I acknowledge and agree that publication of said photos confers no rights of ownership or royalties whatsoever.

I hereby release the Center for Exercise Medicine and Rehabilitation, its contractors, its employees. And any third parties involved in the creation or publication of marketing materials, from liability for any claims by me or any third party in connection with my participation.

I have read and understand this policy. I hereby agree with this policy with my signature below.

Patient/Parent Name Signature Date

Thank you for your continued support of VSU and the Center for Exercise Medicine and Rehabilitation!

2022 PAR-Q+

The Physical Activity Readiness Questionnaire for Everyone

The health benefits of regular physical activity are clear; more people should engage in physical activity every day of the week. Participating in physical activity is very safe for MOST people. This questionnaire will tell you whether it is necessary for you to seek further advice from your doctor OR a qualified exercise professional before becoming more physically active.

GENERAL HEALTH QUESTIONS

Please read the 7 questions below carefully and answer each one honestly: check YES or **NO**.	YES	NO
1) Has your doctor ever said that you have a heart condition ☐ **OR** high blood pressure ☐?	☐	☐
2) Do you feel pain in your chest at rest, during your daily activities of living, **OR** when you do physical activity?	☐	☐
3) Do you lose balance because of dizziness **OR** have you lost consciousness in the last 12 months? Please answer **NO** if your dizziness was associated with over-breathing (including during vigorous exercise).	☐	☐
4) Have you ever been diagnosed with another chronic medical condition (other than heart disease or high blood pressure)? **PLEASE LIST CONDITION(S) HERE:** _____	☐	☐
5) Are you currently taking prescribed medications for a chronic medical condition? **PLEASE LIST CONDITION(S) AND MEDICATIONS HERE:** _____	☐	☐
6) Do you currently have (or have had within the past 12 months) a bone, joint, or soft tissue (muscle, ligament, or tendon) problem that could be made worse by becoming more physically active? Please answer **NO** if you had a problem in the past, but it **does not limit your current ability** to be physically active. **PLEASE LIST CONDITION(S) HERE:** _____	☐	☐
7) Has your doctor ever said that you should only do medically supervised physical activity?	☐	☐

If you answered NO to all of the questions above, you are cleared for physical activity.
Please sign the PARTICIPANT DECLARATION. You do not need to complete Pages 2 and 3.

- Start becoming much more physically active – start slowly and build up gradually.
- Follow Global Physical Activity Guidelines for your age (https://www.who.int/publications/i/item/9789240015128).
- You may take part in a health and fitness appraisal.
- If you are over the age of 45 yr and NOT accustomed to regular vigorous to maximal effort exercise, consult a qualified exercise professional before engaging in this intensity of exercise.
- If you have any further questions, contact a qualified exercise professional.

PARTICIPANT DECLARATION

If you are less than the legal age required for consent or require the assent of a care provider, your parent, guardian or care provider must also sign this form.

I, the undersigned, have read, understood to my full satisfaction and completed this questionnaire. I acknowledge that this physical activity clearance is valid for a maximum of 12 months from the date it is completed and becomes invalid if my condition changes. I also acknowledge that the community/fitness center may retain a copy of this form for its records. In these instances, it will maintain the confidentiality of the same, complying with applicable law.

NAME _____ DATE _____

SIGNATURE _____ WITNESS _____

SIGNATURE OF PARENT/GUARDIAN/CARE PROVIDER _____

If you answered YES to one or more of the questions above, COMPLETE PAGES 2 AND 3.

Delay becoming more active if:

- You have a temporary illness such as a cold or fever; it is best to wait until you feel better.
- You are pregnant - talk to your health care practitioner, your physician, a qualified exercise professional, and/or complete the ePARmed-X+ at www.eparmedx.com before becoming more physically active.
- Your health changes - answer the questions on Pages 2 and 3 of this document and/or talk to your doctor or a qualified exercise professional before continuing with any physical activity program.

01-11-2021

2022 PAR-Q+

FOLLOW-UP QUESTIONS ABOUT YOUR MEDICAL CONDITION(S)

1. Do you have Arthritis, Osteoporosis, or Back Problems?

If the above condition(s) is/are present, answer questions 1a-1c — If **NO** ☐ go to question 2

1a.	Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer **NO** if you are not currently taking medications or other treatments)	YES ☐ NO ☐
1b.	Do you have joint problems causing pain, a recent fracture or fracture caused by osteoporosis or cancer, displaced vertebra (e.g., spondylolisthesis), and/or spondylolysis/pars defect (a crack in the bony ring on the back of the spinal column)?	YES ☐ NO ☐
1c.	Have you had steroid injections or taken steroid tablets regularly for more than 3 months?	YES ☐ NO ☐

2. Do you currently have Cancer of any kind?

If the above condition(s) is/are present, answer questions 2a-2b — If **NO** ☐ go to question 3

2a.	Does your cancer diagnosis include any of the following types: lung/bronchogenic, multiple myeloma (cancer of plasma cells), head, and/or neck?	YES ☐ NO ☐
2b.	Are you currently receiving cancer therapy (such as chemotheraphy or radiotherapy)?	YES ☐ NO ☐

3. Do you have a Heart or Cardiovascular Condition? This includes Coronary Artery Disease, Heart Failure, Diagnosed Abnormality of Heart Rhythm

If the above condition(s) is/are present, answer questions 3a-3d — If **NO** ☐ go to question 4

3a.	Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer **NO** if you are not currently taking medications or other treatments)	YES ☐ NO ☐
3b.	Do you have an irregular heart beat that requires medical management? (e.g., atrial fibrillation, premature ventricular contraction)	YES ☐ NO ☐
3c.	Do you have chronic heart failure?	YES ☐ NO ☐
3d.	Do you have diagnosed coronary artery (cardiovascular) disease and have not participated in regular physical activity in the last 2 months?	YES ☐ NO ☐

4. Do you currently have High Blood Pressure?

If the above condition(s) is/are present, answer questions 4a-4b — If **NO** ☐ go to question 5

4a.	Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer **NO** if you are not currently taking medications or other treatments)	YES ☐ NO ☐
4b.	Do you have a resting blood pressure equal to or greater than 160/90 mmHg with or without medication? (Answer **YES** if you do not know your resting blood pressure)	YES ☐ NO ☐

5. Do you have any Metabolic Conditions? This includes Type 1 Diabetes, Type 2 Diabetes, Pre-Diabetes

If the above condition(s) is/are present, answer questions 5a-5e — If **NO** ☐ go to question 6

5a.	Do you often have difficulty controlling your blood sugar levels with foods, medications, or other physician-prescribed therapies?	YES ☐ NO ☐
5b.	Do you often suffer from signs and symptoms of low blood sugar (hypoglycemia) following exercise and/or during activities of daily living? Signs of hypoglycemia may include shakiness, nervousness, unusual irritability, abnormal sweating, dizziness or light-headedness, mental confusion, difficulty speaking, weakness, or sleepiness.	YES ☐ NO ☐
5c.	Do you have any signs or symptoms of diabetes complications such as heart or vascular disease and/or complications affecting your eyes, kidneys, **OR** the sensation in your toes and feet?	YES ☐ NO ☐
5d.	Do you have other metabolic conditions (such as current pregnancy-related diabetes, chronic kidney disease, or liver problems)?	YES ☐ NO ☐
5e.	Are you planning to engage in what for you is unusually high (or vigorous) intensity exercise in the near future?	YES ☐ NO ☐

01-11-2021

2022 PAR-Q+

6. **Do you have any Mental Health Problems or Learning Difficulties?** This includes Alzheimer's, Dementia, Depression, Anxiety Disorder, Eating Disorder, Psychotic Disorder, Intellectual Disability, Down Syndrome

If the above condition(s) is/are present, answer questions 6a-6b If **NO** ☐ go to question 7

6a.	Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer **NO** if you are not currently taking medications or other treatments)	YES ☐ NO ☐
6b.	Do you have Down Syndrome **AND** back problems affecting nerves or muscles?	YES ☐ NO ☐

7. **Do you have a Respiratory Disease?** *This includes Chronic Obstructive Pulmonary Disease, Asthma, Pulmonary High Blood Pressure*

If the above condition(s) is/are present, answer questions 7a-7d If **NO** ☐ go to question 8

7a.	Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer **NO** if you are not currently taking medications or other treatments)	YES ☐ NO ☐
7b.	Has your doctor ever said your blood oxygen level is low at rest or during exercise and/or that you require supplemental oxygen therapy?	YES ☐ NO ☐
7c.	If asthmatic, do you currently have symptoms of chest tightness, wheezing, laboured breathing, consistent cough (more than 2 days/week), or have you used your rescue medication more than twice in the last week?	YES ☐ NO ☐
7d.	Has your doctor ever said you have high blood pressure in the blood vessels of your lungs?	YES ☐ NO ☐

8. **Do you have a Spinal Cord Injury?** *This includes Tetraplegia and Paraplegia*

If the above condition(s) is/are present, answer questions 8a-8c If **NO** ☐ go to question 9

8a.	Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer **NO** if you are not currently taking medications or other treatments)	YES ☐ NO ☐
8b.	Do you commonly exhibit low resting blood pressure significant enough to cause dizziness, light-headedness, and/or fainting?	YES ☐ NO ☐
8c.	Has your physician indicated that you exhibit sudden bouts of high blood pressure (known as Autonomic Dysreflexia)?	YES ☐ NO ☐

9. **Have you had a Stroke?** *This includes Transient Ischemic Attack (TIA) or Cerebrovascular Event*

If the above condition(s) is/are present, answer questions 9a-9c If **NO** ☐ go to question 10

9a.	Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer **NO** if you are not currently taking medications or other treatments)	YES ☐ NO ☐
9b.	Do you have any impairment in walking or mobility?	YES ☐ NO ☐
9c.	Have you experienced a stroke or impairment in nerves or muscles in the past 6 months?	YES ☐ NO ☐

10. **Do you have any other medical condition not listed above or do you have two or more medical conditions?**

If you have other medical conditions, answer questions 10a-10c If **NO** ☐ read the Page 4 recommendations

10a.	Have you experienced a blackout, fainted, or lost consciousness as a result of a head injury within the last 12 months **OR** have you had a diagnosed concussion within the last 12 months?	YES ☐ NO ☐
10b.	Do you have a medical condition that is not listed (such as epilepsy, neurological conditions, kidney problems)?	YES ☐ NO ☐
10c.	Do you currently live with two or more medical conditions?	YES ☐ NO ☐

PLEASE LIST YOUR MEDICAL CONDITION(S) AND ANY RELATED MEDICATIONS HERE: _____

_____

GO to Page 4 for recommendations about your current medical condition(s) and sign the PARTICIPANT DECLARATION.

2022 PAR-Q+

If you answered NO to all of the FOLLOW-UP questions (pgs. 2-3) about your medical condition, you are ready to become more physically active - sign the PARTICIPANT DECLARATION below:

- It is advised that you consult a qualified exercise professional to help you develop a safe and effective physical activity plan to meet your health needs.
- You are encouraged to start slowly and build up gradually - 20 to 60 minutes of low to moderate intensity exercise, 3-5 days per week including aerobic and muscle strengthening exercises.
- As you progress, you should aim to accumulate 150 minutes or more of moderate intensity physical activity per week.
- If you are over the age of 45 yr and **NOT** accustomed to regular vigorous to maximal effort exercise, consult a qualified exercise professional before engaging in this intensity of exercise.

If you answered **YES** to **one or more of the follow-up questions** about your medical condition:

You should seek further information before becoming more physically active or engaging in a fitness appraisal. You should complete the specially designed online screening and exercise recommendations program - the **ePARmed-X+ at www.eparmedx.com** and/or visit a qualified exercise professional to work through the ePARmed-X+ and for further information.

Delay becoming more active if:

- You have a temporary illness such as a cold or fever; it is best to wait until you feel better.
- You are pregnant - talk to your health care practitioner, your physician, a qualified exercise professional, and/or complete the ePARmed-X+ **at www.eparmedx.com** before becoming more physically active.
- Your health changes - talk to your doctor or qualified exercise professional before continuing with any physical activity program.

- You are encouraged to photocopy the PAR-Q+. You must use the entire questionnaire and NO changes are permitted.
- The authors, the PAR-Q+ Collaboration, partner organizations, and their agents assume no liability for persons who undertake physical activity and/or make use of the PAR-Q+ or ePARmed-X+. If in doubt after completing the questionnaire, consult your doctor prior to physical activity.

PARTICIPANT DECLARATION

- All persons who have completed the PAR-Q+ please read and sign the declaration below.
- If you are less than the legal age required for consent or require the assent of a care provider, your parent, guardian or care provider must also sign this form.

I, the undersigned, have read, understood to my full satisfaction and completed this questionnaire. I acknowledge that this physical activity clearance is valid for a maximum of 12 months from the date it is completed and becomes invalid if my condition changes. I also acknowledge that the community/fitness center may retain a copy of this form for records. In these instances, it will maintain the confidentiality of the same, complying with applicable law.

NAME _____ DATE _____

SIGNATURE _____ WITNESS _____

SIGNATURE OF PARENT/GUARDIAN/CARE PROVIDER _____

For more information, please contact
www.eparmedx.com
Email: eparmedx@gmail.com

Citation for PAR-Q+
Warburton DER, Jamnik VK, Bredin SSD, and Gledhill N on behalf of the PAR-Q+ Collaboration. The Physical Activity Readiness Questionnaire for Everyone (PAR-Q+) and Electronic Physical Activity Readiness Medical Examination (ePARmed-X+). Health & Fitness Journal of Canada 4(2):3-23, 2011.

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Key References

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2. Warburton DER, Gledhill N, Jamnik VK, Bredin SSD, McKenzie DC, Stone J, Charlesworth S, and Shephard RJ. Evidence-based risk assessment and recommendations for physical activity clearance; Consensus Document. APNM 36(S1):S266-s298, 2011.
3. Chisholm DM, Collis ML, Kulak LL, Davenport W, and Gruber N. Physical activity readiness. British Columbia Medical Journal. 1975;17:375-378.
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01-11-2021

VALDOSTA STATE UNIVERSITY HUMAN PERFORMANCE LAB - HEALTH HISTORY QUESTIONNAIRE

Name: _____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Home/Cell Phone: _____ Work Phone: _____

Email: _____ Preferred contact method: Phone Email

Employer: _____ Highest Education: HS BS MS Professional Degree

Sex: M F DOB: _____ Age: _____ Marital Status: Single Married

Race: White Black Asian Hispanic Other (Specify): _____

Emergency Contact: _____ Phone: _____ Relationship: _____

Personal Physician: _____ Location: _____ Phone: _____

Date/Reason for Last Visit? _____ Have you ever had an exercise stress test? Yes No Date: _____

Date/Result of Last Cholesterol Test: _____ Date/Result of Last Blood Glucose/Sugar Test: _____

PERSONAL HEALTH HISTORY

Have you ever had or been told that you have...

	NO	YES
Anemia	☐	☐
Angina/chest pain	☐	☐
Any heart surgery	☐	☐
Any heart trouble	☐	☐
Arthritis/joint pain	☐	☐
Asthma/bronchitis	☐	☐
Back pain/injury	☐	☐
Cancer	☐	☐
Diabetes	☐	☐
Disease of the arteries	☐	☐
Eating disorder	☐	☐
Emboli(us) or Phlebitis	☐	☐
Emphysema	☐	☐
Heart attack	☐	☐
Heart murmur	☐	☐
High blood pressure	☐	☐
High cholesterol	☐	☐
Hospitalizations	☐	☐
Joint/muscle swelling	☐	☐
Osteoporosis	☐	☐
Stroke	☐	☐
Varicose Veins	☐	☐

PRESENT SYMPTOMS

Do you currently have or have had in last 3 months...

	NO	YES
Allergies: _____	☐	☐
Blood in urine/stool	☐	☐
Chest pain/discomfort	☐	☐
Common cold/sinusitis	☐	☐
Coughing of blood	☐	☐
Coughing on exertion	☐	☐
Frequent headaches	☐	☐
Indigestion/heartburn	☐	☐
Lightheaded/dizzy	☐	☐
Rapid heart beat	☐	☐
Skipped heart beats	☐	☐
Shortness of breath	☐	☐
Pain in jaw/neck/arm/ shoulder	☐	☐

ALCOHOL

Do you drink alcohol? ☐ ☐

How much in 1 week?

Beer _____ can/bottle

Wine _____ glasses

Hark liquor _____ drinks

CAFFEINE

How much do you drink per day?

Coffee _____ cups Tea _____ cups

Soft drinks _____ cans/bottles

Energy drinks _____ cans/bottles

FAMILY HEALTH HISTORY

Have any immediate family or grandparents had?

	NO	YES
Angina/chest pain	☐	☐
Any heart surgery	☐	☐
Diabetes	☐	☐
Heart attack	☐	☐
Heart disease	☐	☐
High blood pressure	☐	☐
High cholesterol	☐	☐
Stroke	☐	☐
Sudden death	☐	☐

TOBACCO HISTORY

Do you currently smoke?	☐	☐
What? Cigarettes	☐	☐
Cigars	☐	☐
Pipe	☐	☐
Chewing tobacco	☐	☐
E-cigarettes	☐	☐
Are you trying to quit?	☐	☐

How much per day? _____

Have you ever quit? Yes No When? ____

How many yrs & how much? _____

Regularly exposed to smoke? _____

CURRENT MEDICATIONS (PRESCRIPTION, NON-PRESCRIPTION, VITAMINS, SUPPLEMENTS)

NAME	REASON	STARTED TAKING?	HOW OFTEN?	DOSAGE?

FEMALES ONLY: Are you premenopausal _____ peri-menopausal _____ post-menopausal _____ (at age ____)
Hormone therapy? _____ Currently _____ Past (for how long _____)

HOSPITALIZATIONS: LIST HOSPITALIZATIONS IN LAST 5 YEARS (EXCEPT NORMAL PREGNANCIES)

DATE	REASON

LIFESTYLE AND PHYSICAL ACTIVITY

How STRESSED do you feel in your daily life? ☐very little ☐fairly ☐somewhat ☐most of time ☐all the time

Why do you want to start an exercise program/routine? (Check all that apply)
☐Doctors recommendation ☐Lose weight ☐Enjoyment ☐Reduce stress
☐Improve appearance ☐Better health ☐Other: _____

Are you currently following a weight reduction program? Yes No For how long and what type of program? _____
_____

How would you rate your occupational activity level (how much activity/how hard activity level at your job)?
☐Sedentary (computer/office work) ☐Light (non-sedentary office work, cashier, teacher, nursing)
☐Moderate (mail carrier, restaurant server) ☐Heavy/vigorous (construction, fire service, fitness instructor)

OVER THE LAST 3 MONTHS, HAVE YOU REGULARLY....
(Mark those that apply and complete corresponding questions)

☐Performed aerobic exercise (walking, jogging, swimming, cycling, aerobics class, Zumba, etc)
What type? _____
Days per week? _____ How many minutes per week? _____
If you walk/jog/run, how many miles do you usually do? _____ What is your average time per mile? _____

☐Played strenuous sports (basketball, tennis, racquetball, soccer, martial arts, etc)
What type? _____
Days per week? _____ How many minutes per week? _____

☐Participated in resistance/strength/weight training (lift weights, body pump class, TRX, etc)
What type? _____
Days per week? _____ How many minutes per week? _____

☐Participated in flexibility, core strengthening, or neuromotor fitness activities (yoga, Pilates, boot camp classes, etc)
What type? _____
Days per week? _____ How many minutes per week? _____

During exercise, do you ever experience any of the following:
☐Uncomfortable shortness of breathe ☐Chest pain/discomfort (Does it go away with rest? Yes No)
☐Lightheaded/dizzy ☐Bone or joint discomfort/swelling
☐Muscle pain/swelling ☐Other problems: _____
Do you have any other medical concerns/problems not already identified? Please list: