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MEMBERSHIP AGREEMENT

Please review this agreement and print the requested information clearly; then sign and date it. You are entitled to a copy of this contract at the time it's signed.

MEMBER INFORMATION

Your Name: _____ Social Security: _____ Birth Date: _____

Home Phone: _____ Cell Phone: _____ Email Address: _____

Address: _____ City, State, Zip: _____

Employer: _____ Work Phone: _____

In Emergency: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____ Other: _____

ACCOUNT INFORMATION

I, _____, authorize my bank or credit card company to make my payment as directed below.

Electronic Fund Transfer Checking / Savings Routing #: Account #: _____

Credit Card #: _____ Expiration Date: _____

Payment Amt: $ _____ 1st Due Date: _____

Your Signature: _____ Date Signed: _____

Staff Signature: _____ Date Signed: _____

MEMBER RIGHTS & AGREEMENT TERMS

Agreement Termination By Member

Any holder of this consumer credit contract is subject to all claims and defenses that the buyer/member could assert against BODYWORKS as a result of this contract. Recovery by the buyer/member shall not exceed the total amount paid by the buyer/member to BODYWORKS pursuant to this contract. You, the buyer, may cancel this agreement by midnight of the third business day after the date of this agreement, and such cancellation must be in writing to BODYWORKS. In the event BODYWORKS closes and ceases to do business, you are no longer obligated to make payments under this agreement.

Agreement Termination By BODYWORKS

If by reason of death or permanent disability, the buyer is unable to continue the membership, buyer or buyer's estate shall be relieved from the obligations of this contract, and if the buyer has prepaid any sum, that amount shall be promptly refunded. Member agrees to follow BODYWORKS rules as from time to time. Violation of our Member Rules & Policies and Procedures may result in the suspension or cancellation of membership with no refund.**

Default & Late Payment

Should you default on any payment obligation as called for in this agreement, the entire remaining balance shall be deemed due and payable upon demand. You agree to pay the allowable interest and all cost of collection, including, but not limited to, bank/credit card fees, collection agency fees, court costs and attorney's fees. Should any monthly payment become more than 10 days past due, you may be charged a late fee to cover additional administrative fees and other expenses related to obtaining your payment.

_____ Member Initials

The Federal Equal Credit Opportunity Act prohibits creditors from discriminating against credit applicants with respect to any aspect of a credit transaction on the basis of race, color, religion, national origin, sex or marital status, or age (provided that the applicant has the capacity to contract). The agency that administers compliance with this law is the Federal Trade Commission, Equal Credit Opportunity Washington, D.C. 20580

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PHYSICAL ACTIVITY READINESS QUESTIONNAIRE

Regular physical activity is fun and healthy, and increasingly more people are starting to become more active every day. Becoming more active is very safe for *most* people. However, some people should check with their Doctor before they start becoming much more physically active.

If you are planning to become much more physically active than you are now, start by answering the seven questions in the box below. If you are between the ages of 15 and 69, this questionnaire (the PAR-Q) will tell you if you should check with your Doctor before you start. If you are over 69 years of age and you are not used to being active, check with your Doctor.

Please read the questions carefully and answer each one honestly. Check the box indicating yes or no. Common sense is your best guide when you answer these questions.

Yes	No		
☐	☐	1.	Has your Doctor ever said that you have a heart condition and that you should only do physical activity recommended by a Doctor?
☐	☐	2.	Do you feel pain in your chest when you do physical activity?
☐	☐	3.	In the past month, have you had pain in your chest while NOT doing physical activity?
☐	☐	4.	Do you lose your balance due to dizziness or do you ever lose consciousness?
☐	☐	5.	Do you have a bone or joint problem that could be made worse by a change in your physical activity?
☐	☐	6.	Is your Doctor presently prescribing drugs (for example, water pills) for your blood pressure or heart condition?
☐	☐	7.	Do you know any other reason that you should not do physical activity?

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INFORMED CONSENT

General Statement of Program Objectives and Procedures

I understand that this physical fitness program may include exercises to build the cardiorespiratory system (heart and lungs), the musculoskeletal system (muscle endurance, strength and flexibility), and to improve body composition (decrease of body fat in individuals needing to loose fat, with an increase in muscle and bone). Exercise may include aerobic activities (treadmill walking/running, bicycle riding, rowing machine exercise, group aerobic activity, swimming, and other such activities), calisthenics, and weight lifting to improve muscular strength and endurance, and flexibility exercises to improve joint range of motion.

Description of Potential Risks

I understand that the reaction of the heart, lung, and blood vessel system to such exercise cannot always be predicted with accuracy. I know there is a risk of certain abnormal changes occurring during or during exercise, which may include abnormalities of blood pressure or heart rate, in effect of functioning of the heart, and in rare instances heart attacks. Use of the weight lifting equipment, and engaging in heavy body calisthenics, can lead to musculoskeletal strains, pain, and injury if adequate warm-up, gradual progression, and safety procedures are not followed. Safety procedures are listed on the wall of the facility. In addition, trained staff members will be supervising during all times to help ensure that these risks are minimized. The staff members are trained in CPR and first aid and regularly practice emergency procedures. Equipment is inspected and maintained on a regular basis.

Description of Potential Benefits

I understand that a program of regular exercise for the heart and lungs, muscles, and joints has many associated benefits. These may include a decrease in body fat, improvement in blood fats and blood pressure, improvement in psychological function, and a decrease in risk of heart disease.

I have read the foregoing information and understand it. Any questions that may have occurred to me have been answered to my satisfaction. I understand that I am free to withdraw from this program without prejudice at any time I desire. I am also free to decline answering specific item or questions during interviews or when filling out questionnaires. The information that is obtained will be treated as privileged and confidential and will not be released or revealed to any person other than my physician without my expressed written consent. The information obtained, however, maybe used for statistical or scientific purpose with my right or privacy retained.

Signature / Date: _____

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HEALTH HISTORY QUESTIONNAIRE

Yes	No	Have you ever had?	Yes	No	Has any immediate family (or grandparents) had?	Yes	No	Have you recently had?
☐	☐	High Blood Pressure	☐	☐	Heart Attack(s)	☐	☐	Chest Pain/Discomfort?
☐	☐	Any Heart Trouble	☐	☐	High Blood Pressure	☐	☐	Shortness of Breathe
☐	☐	Disease of the Arteries	☐	☐	High Cholesterol	☐	☐	Heart Palpitations
☐	☐	Varicose Veins	☐	☐	Stroke	☐	☐	Skipped Heart Beats
☐	☐	Lung Disease	☐	☐	Diabetes	☐	☐	Cough on Exertion
☐	☐	Asthma	☐	☐	Congenital Heart Disease	☐	☐	Coughing Up Blood
☐	☐	Kidney Disease	☐	☐	Heart Operation(s)	☐	☐	Dizzy Spells
☐	☐	Hepatitis	☐	☐	Early Death	☐	☐	Frequent Headaches
☐	☐	Diabetes	☐	☐	Mental Illness	☐	☐	Frequent Colds
☐	☐	Heart Murmur	☐	☐	Specify Mental Illness	☐	☐	Back Pain
☐	☐	Arthritis	☐	☐	Depression	☐	☐	Mental Health Treatment
☐	☐	Orthopedic Problems	☐	☐	Other Family Issues	☐	☐	Anxiety
____		Past History Score	____		Family History Score	____		Present Symptom Score

		Have you been diagnosed with/had:	If yes, please indicate *when* and other requested details.	Score
☐	☐	Diabetes	☐ Type 1 ☐ Type II ☐ HBA1C	
☐	☐	High Blood Pressure	Date and results of last reading	
☐	☐	Cancer		
☐	☐	Lung Disease		
☐	☐	Heart Attack		
☐	☐	Stroke		
☐	☐	Neuromuscular Conditions	(Parkinson's, Multiple Sclerosis, etc.)	

☐ ☐ Are you taking any prescription or non-prescription medication (including birth control). If yes, list:

Medication	Reason For Taking It	How Long Taking It	Score

☐ ☐ Have you ever had your cholesterol measured? If yes, please indicate:
Score: Where: When: _____ Score

☐ ☐ Have you ever had your glucose (blood sugar) measured? If yes, please indicate:
Score: Where: When: _____ Score

☐ ☐ Do you drink alcohol? If yes, per week, #____ cans of beer #____ glasses of wine #____ hard liquor drinks _____ Score

☐ ☐ Do you currently use tobacco? If yes, ☐ cigarettes ☐ cigar ☐ pipe ☐ chew and the #____ each day. _____ Score

☐ ☐ Have you ever quit smoking? If yes, when _____? How much and # of years did you smoke? _____ Score

☐ ☐ Have you had hospitalizations or surgeries that aren't yet listed? If yes, please describe: _____ Score

☐ ☐ Do you have any other medical problems/concerns that have not been listed? If yes, please describe: _____ Score

Signature _____ Date: _____

ACSM Score: _____ Total History Score: _____ Sign: _____ Date: _____

Recommend: _____