

**BANNER NEURO WELLNESS  
MEMBERSHIP PACKET**

Name: \_\_\_\_\_ Date: \_\_\_\_\_ E-mail: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 Currently employed: Yes \_\_\_ No \_\_\_ Past or Present Profession \_\_\_\_\_  
 Sex: Male \_\_\_ Female \_\_\_ Marital Status: Single \_\_\_ Married \_\_\_ Div. \_\_\_ Wid. \_\_\_  
 Spouse-Caregiver Name \_\_\_\_\_ Phone: \_\_\_\_\_  
 Emergency Contact Info/Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Neurologist: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Is your Neurologist a Movement Disorder Specialists? Yes \_\_\_ No \_\_\_  
 Primary Care Physician: \_\_\_\_\_ Phone: \_\_\_\_\_  
 How did you hear about BNW? \_\_\_\_\_

**MEDICATIONS**

List any medications you are taking, with dose and how often.

Medication Name:	Dose:	How often?

**MEDICAL HISTORY**

Please check all that apply

CONDITION:	ONSET DATE:	CONDITION:	ONSET DATE:	CONDITION:	ONSET DATE:
Alzheimer's disease		Coronary Artery Disease		Memory Impairment	
Anemia		Dementia		Mutiple Sclerosis	
Angina		Depression		Myocardial Infarction	
Anxiety		Diabetes		Osteoporosis	
Arthritis		High Cholesterol		Parkinson's disease	
Asthma		Gallbladder disease		Renal disease	
Ataxia		GERD		Seizure disorder	
Atrial Fibrillation		Headache, Migraine		Stroke	
Blood Clots		Heart Disease		TIA	
Cancer		Heart Valve Disorder		Thyroid disease	
Cardiac Arrhythmia		Hepatitis / Liver disease		Renal disease	
COPD		Huntingtons disease		PSP	

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Hypertension:    Sitting blood pressure: \_\_\_\_\_ / \_\_\_\_\_    Standing blood pressure: \_\_\_\_\_ / \_\_\_\_\_  
 Hypercholesterolemia:    Total serum cholesterol: \_\_\_\_\_    HDL: \_\_\_\_\_    LDL: \_\_\_\_\_  
 Impaired Fasting Glucose:    Fasting blood glucose: \_\_\_\_\_  
 Obesity:    Weight: \_\_\_\_\_    Height: \_\_\_\_\_    BMI: \_\_\_\_\_

**Other medical problems:**

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**MAJOR SIGNS OR SYMPTOMS**

Do you have any of the following? (Check all that apply)

<input type="checkbox"/>	Pain, discomfort (or other angina equivalent) in the chest, neck, jaw, arms, or other areas that may be due to ischemia
<input type="checkbox"/>	Shortness of breath at rest or with mild exertion
<input type="checkbox"/>	Dizziness or syncope
<input type="checkbox"/>	Orthopnea or paroxysmal nocturnal dyspnea
<input type="checkbox"/>	Ankle edema
<input type="checkbox"/>	Palpitations or tachycardia
<input type="checkbox"/>	Intermittent claudication
<input type="checkbox"/>	Known heart murmur
<input type="checkbox"/>	Unusual fatigue or shortness of breath with usual activities

**Comments:**

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*I understand that the exercise physiologist does not diagnose illness, disease or other physical/mental disorders and nothing communicated in classes/attendance shall be constructed as such. I understand that Banner Neuro Wellness is not a substitute for medical care and that it is my responsibility to let the exercise physiologist and other staff know of any medical conditions I may have. I hereby release the exercise physiologist and/or staff of any responsibility for injury resulting from any medical condition.*

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_ **Time:** \_\_\_\_\_

**Comments (staff only):**

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**FAMILY HISTORY**

Do you have a family history of? (circle one)

Myocardial infarction	Yes	No
Coronary revascularization	Yes	No
Sudden death before 55 years of age in father or other male first-degree relative (brother, son)	Yes	No
Sudden death before 65 years of age in mother or other female first-degree relative (sister, daughter)	Yes	No

**SOCIAL HISTORY**

Cigarette Smoking	Are you a cigarette smoker or have you quit within the previous 6 months?	Yes	No
Sedentary Lifestyle	Do you participate in a regular exercise program or meet the minimal physical activity recommendations from the U.S. Surgeon General's Report?	Yes	No

**PAR-Q**

(circle one)

1. Has your doctor ever said that you have a heart condition AND that you should only do physical activity recommended by a doctor?	Yes	No
2. Do you feel pain in your chest when you do physical activity?	Yes	No
3. In the past month, have you had chest pain when you were not doing physical activity?	Yes	No
4. Do you lose your balance because of dizziness or do you ever lose consciousness?	Yes	No
5. Do you have a bone or joint problem (for example, back, knee or hip) that could be made worse by a change in your physical activity?	Yes	No
6. Is your doctor currently prescribing drugs (for example, water pills) for your blood pressure or heart condition?	Yes	No
7. Do you know of any other reason why you should not do physical activity?	Yes	No

**If you answered YES to one or more questions:**

Talk with your doctor by phone or in person BEFORE you start becoming more physically active or BEFORE you have a fitness appraisal. Tell your doctor about the PAR-Q and which questions you answered YES.

**If you answered NO to all questions:**

You can be reasonably sure that you can start becoming more physically active beginning slowly and building up gradually. You may also take part in a fitness appraisal.

I have discussed the previous information with the Exercise Physiologist and understand that I should always consult my physician before becoming more physically active.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_ **Time:** \_\_\_\_\_



**BANNER NEURO WELLNESS  
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MEMBERSHIP AGREEMENT**

- Banner Neuro Wellness does not provide Physical Therapy and should not be used to replace physician ordered therapy services.
- Each new or returning member must make an appointment for a one-on-one consultation and evaluation with one of our Exercise Physiologists. There will be a **\$50 consultation fee** that will be charged at the time of the consultation.
- Membership and class availability are limited. Therefore, if a member discontinues enrollment, reenrollment is not guaranteed. If membership is discontinued for equal to or greater than 3-months or if disenrollment is due to a medical event the member will need to receive a consultation to renew membership. This will result in an additional \$50 consultation fee.
- The monthly membership fee is \$55.00 due on the 1st of each month.
- Membership dues may be made using a credit card, check, or cash.
- Banner Neuro Wellness requires written notice if a member chooses to withdraw membership. Membership will be canceled 30-days from the date of notice. No refunds will be issued.
- I give permission to Banner Neuro Wellness to contact and communicate with my physician/neurologist regarding my progress to support the continuum of care.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

- A fitness assessment will be conducted upon registration. This will determine the proper fitness modality for each individual member prior to beginning exercise. Class size is limited. Therefore, members are required to sign-up for participation beforehand.
- We strongly encourage our members to take full advantage of all scheduled activities.
- In addition, some specialty or elective activities may have a materials or participation fee if the member chooses to attend. These special sessions will have a sign-up sheet and members can pay per session for participation.
- At any point in time a member becomes unsafe and/or has cognitive challenges/deficits the member must be escorted to, from and in-between classes by an adult family member or designated care giver.
- Banner Neuro Wellness has the right to terminate membership of an individual for any reason up to and including suspicion that the individual may be unsafe to himself/herself or to others in the center activities.
- Banner Neuro Wellness is not responsible for any lost or stolen personal property. A storage shelf with no lock is provided to keep personal belongings during classes.
- Members must wear proper fitness attire for exercise sessions. This includes: loose fitting clothing that doesn't restrict movement and closed-toe gym shoes with socks (no leather-style casual/dress shoes or sandals) ("Shape-up" style shoes are prohibited).
- One water bottle and cups are provided to all members at no charge. Any water that a member brings or has been provided must remain in the designated areas as stated by the staff. All drinks must have a closeable cap. Only water is allowed during fitness activities in the gym area.

*I have read the above membership agreement; I understand and agree with the membership agreement:*

Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_



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**WAIVER, RELEASE, AND ASSUMPTION OF RISK**

I, \_\_\_\_\_, have volunteered to participate in a fitness program provided to me by Banner Health which may include, but may not be limited to, flexibility training, resistance training and aerobic or cardiovascular exercise. In consideration of Banner Health's agreement to instruct and train me, I do here now and forever release and discharge and hereby hold harmless Banner Health and its respective agents, heirs, assigns, contractors, and employees from any and all claims, demands, damages, rights of action or causes of action, present or future, arising out of or connected with my participation in this or any exercise program including any injuries resulting there from. THIS WAIVER AND RELEASE OF LIABILITY INCLUDES, WITHOUT LIMITATION, INJURIES WHICH MAY OCCUR AS A RESULT OF (1) EQUIPMENT BELONGING TO BANNER HEALTH OR TO MYSELF THAT MAY MALFUNCTION OR BREAK; (2) ANY SLIP, FALL, DROPPING OF EQUIPMENT; (3) AND/OR NEGLIGENT INSTRUCTION OR SUPERVISION.

I, \_\_\_\_\_, have been informed of, understand and am aware that any exercise program, whether requiring the use of equipment, is a potentially hazardous activity. I also have been informed of, understand and am aware that any exercise and/or fitness activities involve a risk of injury, as well as abnormal changes in blood pressure, fainting, and a remote risk of heart attack, stroke, other serious disability or death, and that I am voluntarily participating in these activities and using equipment and machinery with full knowledge, understanding and appreciation of the dangers involved. I hereby agree to expressly assume and accept all risks of injury, regardless of severity, or death.

I have been advised that an examination by and medical clearance from a physician should be obtained prior to commencing a fitness and/or exercise program or initiating a substantial change in the amount of regular physical activity performed. If I have chosen not to obtain a physician's clearance prior to beginning this fitness program with Banner Health, I hereby agree that I am doing so solely at my own risk. In any event, I acknowledge and agree that I assume the risk associated with all fitness related activities and/or exercises in which I participate. I ACKNOWLEDGE THAT I HAVE THOROUGHLY READ THIS FORM IN ITS ENTIRETY AND FULLY UNDERSTAND THAT IT IS A RELEASE OF LIABILITY. BY SIGNING THIS DOCUMENT, I AM WAIVING ANY RIGHT I OR MY SUCCESSORS MIGHT HAVE TO BRING A LEGAL ACTION OR ASSERT A CLAIM AGAINST BANNER HEALTH, FOR INCLUDING NEGLIGENCE OF BANNER HEALTH EMPLOYEES, AGENTS, OR CONTRACTORS.

*This form is an important legal document that explains the risks you are assuming by beginning an exercise program. It is critical that you have read and understand this document completely. If you do not understand any part of this document, it is your ultimate responsibility to ask for clarification prior to signing it.*

Participant's Name (Please print) \_\_\_\_\_

Participant's Signature \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_



**BANNER NEURO WELLNESS  
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AUTHORIZATION**

**ALL PHOTO/VIDEO AND RELATED MATERIALS**

I agree \_\_\_\_\_ or I do not agree \_\_\_\_\_ that my participation in any photos taken or audio-visual recordings made by the staff of Banner Neuro Wellness, or any person(s) assisting them, may be used for brochures or other printed materials, TV broadcasts, and social media sites such as Facebook.

If I agree, I may revoke this authorization at any time by notifying a BNW staff person. I understand and agree that only future photos/videos are affected by my revocation.

My participation in any BNW classes or events will not be affected if I do not agree to the above discussed authorization or if I choose to revoke any previously authorized action.

**BNW DIRECTORY**

I consent \_\_\_\_\_ or I do not consent \_\_\_\_\_ to allow my contact information to be included in the BNW Directory, which is shared with all BNW participants.

If I consent, I may revoke this authorization at any time by notifying a BNW staff person. I understand that my contact info will not be included in any future publication. But directories already printed may be distributed.

My participation in any BNW classes or events will not be affected if I do not consent to the above discussed authorization or if I choose to revoke any previously authorized action.

Signature of Member \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_

Printed name \_\_\_\_\_