# Weight Management Program

Baylor Tom Landry Fitness Center
411 N. Washington
Dallas, TX 75246
(214) 820-7996
*Fax* (214) 820-7878

**PROGRAM REGISTRATION AND AGREEMENT FORM**

**Name: _____ Date: _____**

**Address: _____**

**City: _____ State: _____ Zip: _____**

**Day Phone: _____ Other Phone: _____**

**Email: _____**

**Gender: _____ DOB: _____**

**Primare Care Physician: _____Phone: _____**

**Program Costs: Member: $729.00 ¡ Paid in full OR ¡ Paid in 3 installments of $243.00**

**Non-Member: $879.00 ¡ Paid in 3 installments of $293.00**

**$829.00 ¡ Paid in full**

**Advanced Exercise Testing: ¡ VO2 $195.00 ¡ RMR $195.00 ¡ Both Tests $345.00**

**Payment Information: (Circle One)**

Master Card Visa American Express Discover Check

**Credit Card Number: _____**

**Expiration Date: _____**

**Signature: _____ Checks made payable to: BTLFC**

**PROGRAM COSTS** – Your program costs include (3) one-on-one sessions with a Registered Dietician; (3) one-on-one Fitness Assessments with an Fitness Specialist; (7) one-on-one Exercise Sessions with a Fitness Specialist; (2) Cholesterol/Blood Work Screenings; "A Journey of Fitness" Booklet; Personal Pedometer; Exercise Band; Unlimited email access to a Master Personal Trainer and Registered Dietician during Business Hours; Unlimited visits to the Baylor Tom Landry Fitness Center; and optional lectures and group exercise activities.

**PROGRAM PERIOD** –Your 12 consecutive week program begins the first Monday of your first scheduled Nutrition appointment. Your program will not begin until your Nutrition appointment is scheduled. You will need to present a Picture ID each time you visit the BTLFC.

**ADJUSTMENTS AND TERMINATIONS** – The participant acknowledges that the Program Costs are for the Weight Management program and the BTLFC reserves the right to terminate enrollment with or without cause, providing written notice of any such terminations. The BTLFC reserves the right to adjust program costs for any future programs it may offer. All payments are non-transferable. No payments will be refunded for reason of non-use of facility or program. All payments are Final. Any cancellation (late or not attending a scheduled appointment) of a Weight Management Program session (i.e. Nutrition, Fitness Assessment, or Exercise Session) constitutes forfeiture of that specific Weight Management Program session.

I hereby understand that enrollment in the program does not constitute membership at BTLFC. Furthermore, I agree to abide by all BTLFC policies when on its premises and using its facilities.

I hereby enroll myself in the Weight Management Program. I represent that I have no current health conditions that would affect my participation in the program. I understand that individual results may vary and I am not guaranteed any particular result from my participation in the program. By voluntarily participating in this program, I recognize and accept all risks associated with it. I hereby release Baylor University Medical Center, Baylor Health Care System and any entity affiliated with the Baylor Health Care System and any of their respective officers, directors, agents, servants, employees and representatives from any and all damages, claims, expenses (including attorneys' fees) or injuries (including death), incurred as a result of my participation in this program.

I have read, understand and agree to comply with the above stated and/or indicated terms, conditions and policies.

_____ _____ _____

**Signature** **Printed Name** **Date**

BAYLOR
Tom Landry
Fitness Center

# *Weight Management Program*
# *Participant Information*

***(Please Print)***
**Dr. _____ Mr. _____ Mrs. _____ Ms. _____**

**Name (Last) _____ (First) _____ (M.I.) _____**

**Date of Birth _____ / _____ / _____ Age _____**

**Primary Care Physician _____ Phone: _____**

**Emergency Contact _____ Phone: _____**

## *Health History*

Medications: Please list all medications currently taken (Include prescription, non-prescription and birth control)
***Please attach or list additional medications on back.***

1) Medication: _____ Reason: _____ How long: ____
2) Medication: _____ Reason: _____ How long: ____
3) Medication: _____ Reason: _____ How long: ____
4) Medication: _____ Reason: _____ How long: ____

**Please answer the following questions accordingly:**

**Yes ____ No ____** Do you currently smoke? If yes, how many per day? _____
If no, did you ever smoke? _____ How long has it been since you quit? _____

**Yes ____ No ____** Do you know your Cholesterol Level? Mg/dl: _____

**Yes ____ No ____** Are you currently pregnant?

**Yes ____ No ____** Do you have Diabetes? Type I _____ Type II _____

**Yes ____ No ____** Do you have asthma? If yes, do you use an inhaler? _____

**Yes ____ No ____** Do you experience chest pain when you perform physical activity?

**Yes ____ No ____** Has your doctor ever told you that you have a heart condition?
If so, what type of heart condition and when was this diagnosed? _____

**Yes ____ No ____** Did you receive treatment or undergo surgery for your heart condition? If yes, are there any restrictions?
_____

**Yes ____ No ____** Are you currently taking any prescription medications for high blood pressure, cholesterol, or a heart condition? If yes, please list _____

**Yes ____ No ____** Do you lose your balance because of dizziness or do you ever lose consciousness?
_____

**Yes ____ No ____** Do you have any muscle or joint problems that are made worse or cause pain when you exercise?
If yes, please explain _____

**Yes ____ No ____** Has a Physical Therapist or Physician treated the above medical problem or injury?
If yes, what recommendations or limitations were given by the Physical Therapist or Physician?
_____

**Yes ____ No ____** Do you have arthritis? If yes, what type and what areas are affected? _____

**Yes ____ No ____** Have you had any surgeries that might limit or cause restrictions to your physical activity? If yes, what type and when was the procedure? _____

**Yes ____ No ____** Are you currently under stress? Rate your stress level on a scale of 1 (Low) to 5 (High) _____

**Yes ____ No ____** Are there any other miscellaneous health issues that you feel should be addressed before beginning an exercise program? If yes, please explain _____

## *Exercise History*

Do you currently engage in regular physical activity? Yes _____ No _____

If yes, How many days per week? _____ How many minutes? _____

How long have you had this program (i.e. weeks/months/years) _____

What types of exercise do you currently participate in? (ie; run, bike, swim, group exercise class, etc.) _____

_____

***If you are under the care of a physician, have recently been under the care of a physician, or have experienced any significant medical problems, this information should be disclosed and clearance from you physician should be obtained. If you have not undergone a physical examination, it is recommended that you do so before beginning an exercise program.***

## CONSENT – PHYSIOLOGICAL TESTING

I, the undersigned, hereby give my informed consent to engage in a series of evaluations, including EXERCISE TESTING AND FUNCTIONAL ASSESSMENT. I understand the purpose of this assessment is to characterize my physiological fitness. I understand that this is not a medical examination, but I will be questioned by an exercise professional before, during and after assessment(s).

My assessment may or may not include body composition, blood pressure, graded exercise test, and a sub-max strength test. The tests may also be stopped if fatigue, shortness of breath or other signs indicate the test should not be continued. There exist the possibilities that certain changes may occur during the exercise test which includes abnormal blood pressure, dizziness, and fainting and heart beat disorders.

The results obtained will be treated as confidential and will not be released or revealed without my written consent. The information obtained however, may be used for statistical or scientific purpose with my right of privacy retained.

I understand to perform these assessments are voluntary and I may also terminate the testing at any time.

I _____ (print name) consent to the above terms.

SIGNED: _____ DATE: _____

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