

Participant Information and Health History

Your completed application is needed to enroll in classes with Seattle Parks and Recreation offered in partnership with Sound Generations. An email address is required to submit your electronic application. If you have ASH Silver and Fit as part of your medical benefits, your Silver and Fit Fitness ID number is required. We encourage you to complete the application in full. This helps us demonstrate how this program is serving people who will benefit the most.

Your answers are strictly confidential. Once your application is submitted an autogenerated confirmation email will be sent.

Personal Information

Name: First MI Last

Is there a nickname that you prefer to use?

Birthdate: (mm/dd/yyyy)

Gender: Female Male Gender

How did you hear about EnhanceFitness?

Contact Information

Street:

City: State: Zip Code:

Phone: Email:

Demographic Information

1a. Do you speak a language other than English at home?

Yes What language?

No

1b. Do you sometimes have difficulty speaking English? Yes No

1c. Do you sometimes have difficulty understanding English? Yes No

Medical Information

9. Do you have health insurance? (Check all that apply.)

Medicare Medicaid Private Insurance

10. Does your insurance plan include Silver and Fit? Yes No

a. Silver and Fit ID Number:

Your Silver and Fit ID number is required in order for American Specialty Health to verify and confirm your eligibility for participation in the EnhanceFitness Program and its associated classes. Silver and Fit participants may attend up to 10 class dates per month.

Health History

Your Name:

Your Home Phone:

Emergency Contact Information:

Name/ relationship:

Phone:

What medications do you take?

Do you have any allergies to food or medications? If yes, please list:

What do you wish to accomplish by participating in this exercise program?

Your Doctor's Name:

Doctor's Phone:

Clinic Name, Mailing Address:

City: State: WA Zip Code:

Chronic Conditions

Have you ever been told by a doctor or other health professional that you have any of the following conditions (Mark all that apply.)

- | | |
|--|---|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Rheumatic disease | <input type="checkbox"/> Hypertension |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Lung disease/ Breathing problems |
| <input type="checkbox"/> Diabetes | OR |
| <input type="checkbox"/> Depression | <input type="checkbox"/> No chronic conditions |

Other Conditions

- | | | |
|--|---|---|
| <input type="checkbox"/> Alzheimer's Disease | <input type="checkbox"/> Fall(s) | <input type="checkbox"/> Parkinson's Disease |
| <input type="checkbox"/> Artificial Joint | <input type="checkbox"/> Foot/ ankle swelling | <input type="checkbox"/> Poor leg circulation |
| - where? | <input type="checkbox"/> Heart attack | - which leg? |
| <input type="checkbox"/> Back problems | <input type="checkbox"/> Heart surgery | <input type="checkbox"/> Seizures or epilepsy |
| <input type="checkbox"/> Blackouts | <input type="checkbox"/> Hernia | <input type="checkbox"/> Severe headaches |
| <input type="checkbox"/> Broken bones | <input type="checkbox"/> Irreg./rapid heart beats | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Chest pain/ angina | <input type="checkbox"/> Knee injuries | <input type="checkbox"/> Smoking |
| <input type="checkbox"/> Cholesterol > 240 | <input type="checkbox"/> Macular degeneration | - #/day: |
| <input type="checkbox"/> Congestive heart failure | <input type="checkbox"/> Memory loss | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Dizziness or blurred vision | <input type="checkbox"/> Multiple sclerosis | <input type="checkbox"/> Surgery in past year |
| <input type="checkbox"/> Double vision | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Unsteadiness |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Pacemaker/ defib. | <input type="checkbox"/> Weakness |

Other conditions or additional information:

Self-Assessment

	Yes	No
Do you believe you are physically fit? _____	<input type="radio"/>	<input type="radio"/>
Are you happy with your current weight? _____	<input type="radio"/>	<input type="radio"/>
Can you stand up from a chair without using the arms? _____	<input type="radio"/>	<input type="radio"/>
Can you get up from the floor without assistance? _____	<input type="radio"/>	<input type="radio"/>
Can you stand on one leg without support? _____	<input type="radio"/>	<input type="radio"/>
Can you walk up and down steps without using the handrail? _____	<input type="radio"/>	<input type="radio"/>
Can you walk around a city block without being short of breath? _____	<input type="radio"/>	<input type="radio"/>

What exercise do you currently do on a regular basis? (Please check all that apply and enter number of times per week next to the right of the exercise name.)

<input type="checkbox"/> Walk	<input type="checkbox"/> Bike	<input type="checkbox"/> Skate	<input type="checkbox"/> Martial Arts
<input type="checkbox"/> Jog	<input type="checkbox"/> Dance	<input type="checkbox"/> Tai Chi	<input type="checkbox"/> Aerobics
<input type="checkbox"/> Row	<input type="checkbox"/> Swim	<input type="checkbox"/> Tennis	<input type="checkbox"/> Other:
<input type="checkbox"/> Yoga	<input type="checkbox"/> Stretch	<input type="checkbox"/> Weight Lift	

Where would you like to attend class if available?

- Garfield Community Center
- Magnuson Community Center
- Meadowbrook Community Center
- Miller Community Center
- Queen Anne Community Center
- Rainier Community Center

I, _____, hereby acknowledge that all the above information is true. I release Sound Generations (Seattle, WA) and all of its agents from all liability for any accident, injury or damages of any kind to persons or property that might occur while I participate in an EnhanceFitness® class.

Signature:

Date:

