Healthy Heart
Exercise for Life

Assessment
- Access forms online during registration
- Health history questionnaire, provides a list of current medications, receives approval from their physician

Intake
Once registered, participants will be scheduled for an assessment to go over health history and perform baseline tests to include the following:
- Sit to stand test
- 6 minute walk test
- Arm curl
- Back scratch test
- Chair sit and reach, Up and go test
- Biometric readings - Blood Pressure, Pulse Oxygen rate, Heart rate monitoring

On-Going Programming
Participants will have the opportunity to choose between a variety of convenient sessions.
- Vitals will be monitored (pulse and oxygen saturation levels, blood pressure, Heart Rate Monitor) before they being their program.
- Participants will receive a tailored program and supervision from either an exercise physiologist/respiratory therapist.
- Participants will be retested every 6-8 weeks to see if they are maintaining or showing improvement.

Program Costs
Program feeds are $130 (month-to-month) – 3 hours of supervised exercise/week with vitals monitored. Trained professionals account for their medical conditions in an inclusive environment. Staff is equipped to respond in the event of an emergency.
Health History Questionnaire

Basic Information

Name __________________________  Birthdate ____________________________
Home Address ________________________________________________
Position __________________________  Telephone ____________________________
Height ___________  Weight _________________  Gender________________________

Regular physical activity is safe for most people; however, some individuals should check with their doctors before they start an exercise program. To help us determine if you should consult with your doctor before starting to exercise at the Inova Joan and Russell Hitt Center for Health Living, please read the following questions carefully and answer each one honestly. All information will be kept confidential. Please check YES or NO.

Medical History

YES  NO
☐  ☐  1. Do you have a heart condition?
☐  ☐  2. Have you experienced a stroke?
☐  ☐  3. Do you have epilepsy?
☐  ☐  4. Are you pregnant?
☐  ☐  5. Do you have diabetes?
☐  ☐  6. Do you have emphysema?
☐  ☐  7. Do you feel pain in your chest when you engage in physical activity?
☐  ☐  8. Do you have chronic bronchitis?
☐  ☐  9. In the past month, have you had chest pain when you were not doing physical activity?
☐  ☐  10. Do you ever lose consciousness or do you ever lose control of your balance due to Chronic dizziness?
☐  ☐  11. Are you currently being treated for a bone or joint problem that restricts you from engaging you in physical activity?
12. Has a physician ever told you or are you aware that you have high blood pressure?

13. Has anyone in your immediate family (parents/brothers/sisters) had a heart attack, stroke, or cardiovascular disease before age 55?

14. Has a physician ever told you or are you aware that you have high cholesterol level?

15. Do you currently smoke?

16. Are you a male over 44 years of age?

17. Are you a female over 54 years of age?

18. Are you currently exercising LESS than 1 hour per week? If you answered no, please list your activities. ____________________________________________

19. Are you currently taking any medication? If yes, please list medications and its Purpose ________________________________________________

____________________________________________________________________

**Goals**

**What are your specific fitness goals at Inova Joan and Russell Hitt Center for Healthy Living? (Check all that apply)**

- Increase strength and endurance
- Improve cardiovascular fitness
- Reduce body fat
- Exercise regularly
- Sports conditioning
- Improve flexibility
- Improve muscle tone
- Increase muscle mass
- Injury rehabilitation
- Other ___________________________

**What are your specific health goals at Inova Joan and Russell Hitt Center for Healthy Living? (Check all that apply)**

- Reduce stress
- Control blood pressure
- Stop smoking
- Improve productivity
- Feel better overall
- Improve nutritional habits
- Control cholesterol
- Achieve balance in life
- Reduce back pain
- Increase my health awareness
What motivated you to join Inova Joan and Russell Hitt Center for Healthy Living? (Check all that apply)

☐ Convenience/location
☐ Team Member Promotion
☐ Attended an Inova health promotion event
☐ Peer support
☐ Medical reasons
☐ Tried our guest pass
☐ Other ____________________________________________

Attestation

I have read, understood, and completed this questionnaire. Any questions that I had were answered to my full satisfaction.

Name________________________________ Date ________________________________

Signature__________________________________________________________________

STAFF USE ONLY

Cleared to exercise___________ Not cleared to exercise___________

Reason__________________________________________________________________

Staff signature __________________________ Date __________________________

Resting heart rate___________ Resting blood pressure _________________

EP ________________________________
Doctor’s Approval Form

(Participants name) ________________________________________ has medical approval to participate in the Healthy Heart and Lung Exercise for Life Program. They are approved for the use of exercise equipment under the supervision of an Exercise Physiologist provided by and/or recommended by Inova Well.

The following restrictions apply (if none, so state):

________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

________________________________________________________________________________

Physician’s Signature

________________________________________________________________________________

Physician’s Name

________________________________________________________________________________

Street Address

City __________________________ State ________________ Zip _________________________

Phone ______________________ Date __________________________

*** Please attach a copy of the results of the latest physical examination.***