

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 begin 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 fees 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**

- | | | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Do you have a heart condition? |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Have you experienced a stroke? |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. Do you have epilepsy? |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. Are you pregnant? |
| <input type="checkbox"/> | <input type="checkbox"/> | 5. Do you have diabetes? |
| <input type="checkbox"/> | <input type="checkbox"/> | 6. Do you have emphysema? |
| <input type="checkbox"/> | <input type="checkbox"/> | 7. Do you feel pain in your chest when you engage in physical activity? |
| <input type="checkbox"/> | <input type="checkbox"/> | 8. Do you have chronic bronchitis? |
| <input type="checkbox"/> | <input type="checkbox"/> | 9. In the past month, have you had chest pain when you were not doing physical activity? |
| <input type="checkbox"/> | <input type="checkbox"/> | 10. Do you ever lose consciousness or do you ever lose control of your balance due to Chronic dizziness? |
| <input type="checkbox"/> | <input type="checkbox"/> | 11. Are you currently being treated for a bone or joint problem that restricts you from engaging you in physical activity? |



YES NO

- 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)

- | | |
|--|--|
| <input type="checkbox"/> Increase strength and endurance | <input type="checkbox"/> Improve flexibility |
| <input type="checkbox"/> Improve cardiovascular fitness | <input type="checkbox"/> Improve muscle tone |
| <input type="checkbox"/> Reduce body fat | <input type="checkbox"/> Increase muscle mass |
| <input type="checkbox"/> Exercise regularly | <input type="checkbox"/> Injury rehabilitation |
| <input type="checkbox"/> Sports conditioning | <input type="checkbox"/> Other _____ |

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

- | | |
|---|---|
| <input type="checkbox"/> Reduce stress | <input type="checkbox"/> Improve nutritional habits |
| <input type="checkbox"/> Control blood pressure | <input type="checkbox"/> Control cholesterol |
| <input type="checkbox"/> Stop smoking | <input type="checkbox"/> Achieve balance in life |
| <input type="checkbox"/> Improve productivity | <input type="checkbox"/> Reduce back pain |
| <input type="checkbox"/> Feel better overall | <input type="checkbox"/> Increase my health awareness |



Other (please be specific) _____

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.**

