



CITY OF ROGERS
ADULT WELLNESS CENTER
 Membership Form

Membership # _____
New _____
Renewal _____
SilverSneakers _____

First: _____ Middle: _____ Last: _____
 (Please Print)

Name I go by: _____ Birth Date: _____

Address: _____ City: _____

State: _____ Zip Code: _____ E-mail: _____

Home Phone: _____ Cell Phone: _____

Gender ___ Male ___ Female

Ethnicity: ___ Caucasian ___ African American ___ Latin
 ___ Multi-racial ___ Native American ___ Other

Household Type: ___ Private Home ___ Public Housing
 ___ Assisted Living ___ Rental

Family Setting: ___ Living alone independently ___ Living with spouse independently
 ___ Living alone with caregiver ___ Living with spouse with caregiver
 ___ Living with extended family

Medical Information:

Note: This section is for pertinent information we can provide to first responders in case of an emergency.

Please list any medications:	Please list any allergies:
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Please check any known medical conditions:

- | | | |
|--------------------------------|--|-------------------------|
| ___ Cognitive Impairment | ___ Hearing Impairment | |
| ___ Mobility Impairment | ___ My Condition requires an attendant | |
| ___ Heart Disease | ___ History of Heart Attack | ___ Chest Pain |
| ___ High Cholesterol | ___ Low Blood Pressure | ___ Epilepsy |
| ___ Multiple Sclerosis | ___ Fibromyalgia | ___ Arthritis |
| ___ Thyroid Disease | ___ Joint Replacement | ___ Asthma |
| ___ Severe Obesity | ___ Kidney Disease | ___ Diabetes |
| ___ Dementia | ___ Parkinson's Disease | ___ Osteoporosis |
| ___ Mental Illness-type: _____ | Other: _____ | ___ High Blood Pressure |
| | | ___ History of Stroke |
| | | ___ Back Injury |
| | | ___ Pulmonary Disease |
| | | ___ Alzheimer's Disease |
| | | ___ Cancer-type: _____ |

****PLEASE TURN OVER TO COMPLETE OTHER SIDE****

Emergency Contact Information: Please list a primary or local emergency contact.

Name: _____ Relationship: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Please list an additional family member or emergency contact:

Name: _____ Relationship: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Please complete the following questions by circling your answer:

Compared with other people your age, how do you rate your own health?

Much better Somewhat better The same Somewhat worse Much worse

How many days a week are you currently exercising?

0 1 2 3 4 5 6 7

How many days a week are you currently participating in social or recreational activities?

0 1 2 3 4 5 6 7

Please rate your current energy level (0 = no energy, 10 = full of energy)

0 1 2 3 4 5 6 7 8 9 10

Do you smoke? ___ No ___ Yes (if yes, number of packs/day) ___

Height _____ Weight _____ Blood Pressure _____ Cholesterol _____

I hereby apply for membership with the City of Rogers Adult Wellness Center. I acknowledge that the center is a fitness and activity center and that its programs, events, and equipment use are on a volunteer basis. The membership fee does not include any insurance coverage. I understand and acknowledge that certain inherent risks exist with all types of physical exercise regardless of whether I am supervised by an instructor or participate in such activity by my own direction. If I am concerned with these risks or with my current health condition, I agree to consult my physician before beginning a new activity or exercise. I further agree that membership is on a yearly basis and that additional fees may be charged if I choose to participate in certain classes or activities. **No refunds will be given for memberships, classes or activities.** I hereby agree to follow all of the policies of the center and I agree that my membership is a privilege and may be revoked by the center's staff.

Member Signature _____ Date _____

Office Use Only:

Notes:

Staff/Volunteer Initials _____ Date _____

Cash _____ Check _____ Ck # _____

Requested Scholarship _____ SilverSneakers ID Number: _____ - _____ - _____ - _____