

REGISTRATION FORM

PLEASE PRINT ALL INFORMATION

Are you a Myerberg Member? Yes No Add/Renew \$_____

Date _____ Birth Date _____

First Name _____ MI _____ Last Name _____

PROGRAM REGISTRATION

CLASS/PROGRAM	DAY	DATES	FEE		
			Priority	Member	Non-Member
			\$		
			\$		
			\$		
			\$		
			\$		
			\$		
			\$		
TOTAL:			\$		

FITNESS REGISTRATION

CLASS/PROGRAM	MEMBER PRICE	NON-MEMBER PRICE	AMOUNT DUE
Evaluation Fee	\$35	\$35	\$
_____ Week (Visitors Only)		\$20/week	\$
13-Week	\$99	\$114	\$
26-Week	\$187	\$208	\$
52-Week	\$348	\$400	\$
52-Week Couples	\$307/person	\$359/person	\$
<i>Office Use Only</i>			
Fitness Exp: ____/____/____	Myerberg Exp: ____/____/____		
TOTAL:			\$

PERSONAL TRAINING REGISTRATION

30-MINUTE PERSONAL TRAINING SESSIONS	MEMBER PRICE	NON-MEMBER PRICE	AMOUNT DUE
Single Session	\$40	\$55	\$
4-Session Package	\$129	\$190	\$
8-Session Package	\$190	\$317	\$
1-HOUR PERSONAL TRAINING SESSIONS	MEMBER PRICE	NON-MEMBER PRICE	AMOUNT DUE
Single Session	\$60	\$75	\$
4-Session Package	\$209	\$270	\$
8-Session Package	\$359	\$473	\$
TOTAL:			\$

Payment is due at the time of registration. Center membership **MUST** be current and remain throughout the duration of the class/program to receive member rate. By your enrollment in classes, The Myerberg has permission to use photography/ videos for publicity purposes.

I'd like to Support the Myerberg's Friends Campaign: \$18 / \$36 / \$50 / Other _____

Cash Credit Card Check Check # _____ Make checks payable to: Myerberg Center

FINAL TOTAL PAID: \$ _____

Mail completed form to:
Edward A. Myerberg Center
3101 Fallstaff Road
Baltimore, MD 21209

Please call 410-358-6856 or 443-963-1448 to register by phone.



Original Date:
Dates Revised:

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will be used only for exercise prescription.

Name:	Date:
Primary Physician:	Physician Phone:

PERSONAL HEALTH HISTORY

List any medical problems that doctors have diagnosed

1. Do you have Arthritis, Osteoporosis, or Back Problems? Yes No
 2. Do you currently have Cancer of any kind? Yes No
 3. Do you have a Heart or Cardiovascular Condition? This includes Coronary Artery Disease, Heart Failure, Diagnosed Abnormality of Heart Rhythm. Yes No
 4. Do you have High Blood Pressure? Yes No
 5. Do you have any Metabolic Conditions? This includes Type 1 Diabetes, Type 2 Diabetes, Pre-Diabetes. Yes No
 6. Do you have any Mental Health Problems or Learning Difficulties? This includes Alzheimer's, Dementia, Depression, Anxiety Disorder, Eating Disorder, Psychotic Disorder, Intellectual Disability, Down Syndrome. Yes No
 7. Do you have a Respiratory Disease? This includes Chronic Obstructive Pulmonary Disease, Asthma, Pulmonary High Blood Pressure. Yes No
 8. Do you have a Spinal Cord Injury? This includes Tetraplegia and Paraplegia. Yes No
 9. Have you had a stroke? Yes No
 10. Do you have any other medical condition not listed above or do you have two or more medical conditions? Yes No
- If yes, please list your medical condition(s):

Surgeries		
Year	Reason	Hospital

Do you use a walking aid? No Yes (circle) Cane / Walker / other

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers		
Name the Drug	Strength	Frequency Taken

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Exercise	<input type="checkbox"/> Sedentary (No exercise)		
	<input type="checkbox"/> Mild exercise (i.e., climb stairs, walk 3 blocks, golf)		
	<input type="checkbox"/> Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)		
	<input type="checkbox"/> Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)		
Personal Safety	Do you live alone?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you have frequent falls?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you have vision or hearing loss?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Notes: _____
