



## Wellness Punch Card Agreement

### Regulations

**Available times:** The Tanger Be Well Center Wellness Punch Card may be used any time during our normal business hours.

**Group Exercise Classes:** You can attend any group exercise class with the Tanger Be Well Wellness Punch Card. Classes are filled on a first come-first served basis. Class size limits are posted and enforced.

**Cost:** 5-visit card for \$55 or a 10-visit card for \$75.

**Non-Transferable:** The Tanger Be Well Wellness Punch Card is non-transferable.

**Lost Cards:** If you lose your Tanger Be Well Wellness Punch Card, you forfeit the remaining punches.

**Expiration date:** The 5-visit card expires after 90 days (three months); the 10-visit card expires after 180 days (six months). If all punches are not used by the expiration date the card becomes invalid and cannot be applied to future purchases.

**Lockers:** Temporary lockers are available for use in the Tanger Be Well Center. **You must bring your own lock.** Please lock up all belongings while you are in the Center. If your belongings are left in a locker over night the lock will be cut off.

**Towels:** Towels are available for your use. Towels can be picked up in the fitness center near the locker rooms.

**Proper attire:** For everyone's safety and comfort while exercising in the Tanger Be Well Center, clean exercise clothing and sneakers are required. Please note that you may not exercise in scrubs.

**Informed Consent:** You need to fill out the Tanger Be Well Center informed consent agreement form before your first visit.

### Please read and sign the following statement.

I, \_\_\_\_\_, have read and understand all the rules and regulations as stated above regarding the use of the Tanger Be Well Center, and I agree to adhere to these policies as written.

Printed name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_

If you would **not** like to be included on the Be Well Group Exercise email list, please initial below. These emails include class cancellations, instructor changes and class changes. \_\_\_\_\_



## TANGER BE WELL CENTER PUNCH CARD APPLICATION

*The information you are providing is considered confidential and will not become part of your medical record. It will be kept on file in the Tanger Be Well Center Office.*

### Demographic Information

Name: \_\_\_\_\_  
(First) (Last) (Middle Initial)

E-mail Address: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender: Male Female

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Primary Care Provider: \_\_\_\_\_

PCP Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_

Relationship: \_\_\_\_\_

Day Phone: \_\_\_\_\_ Evening Phone: \_\_\_\_\_

Referred to Tanger Be Well Center by \_\_\_\_\_

### Medical Information

1. Do you experience any of the following (please check all that apply)?

- |   |   |
|---|---|
| <input type="checkbox"/> <b>Arthritis/Fibromyalgia*</b>   | <input type="checkbox"/> Asthma                                   |
| <input type="checkbox"/> <b>Diabetes*</b>                 | <input type="checkbox"/> Cancer (past or present)                 |
| <input type="checkbox"/> <b>Epilepsy*</b>                 | <input type="checkbox"/> Family history of Heart Disease          |
| <input type="checkbox"/> <b>Heart disease/chest pain*</b> | <input type="checkbox"/> High blood cholesterol                   |
| <input type="checkbox"/> <b>Irregular heart beat*</b>     | <input type="checkbox"/> High blood pressure                      |
| <input type="checkbox"/> <b>Neuromuscular disorders</b>   | <input type="checkbox"/> Metabolic disorders (hyper/hypo thyroid) |
| <input type="checkbox"/> <b>(MS, Parkinson's)*</b>        | <input type="checkbox"/> Obesity                                  |
| <input type="checkbox"/> Other _____                      |   |

**\* Medical clearance is needed for any conditions in bold**



2. Do you have any current or past injuries that limit the movement of your muscles, joints or other part of your body (i.e., spine, knee, neck), and could be aggravated by exercise?

YES NO If yes, please explain:

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3. Are you presently receiving physical therapy? YES NO If yes, for what reason?

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Physical Therapist Name: \_\_\_\_\_ Phone: \_\_\_\_\_

4. What medication, vitamins, or hormones (either prescription or over-the-counter) are you presently taking or have just recently (within the past 3 months) completed taking?

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5. Have you ever smoked? YES NO

Do you currently smoke cigarettes? YES NO

If yes, how many cigarettes per day? \_\_\_\_\_

If you've quit, how long has it been since you've smoked? \_\_\_\_\_ Months

6. How many times per week do you get aerobic physical activity, such as jogging, swimming, cycling, walking, or other activities that increase your heart rate? \_\_\_\_\_

On average, how long is each exercise session? \_\_\_\_\_

7. How many times per week do you get an aerobic physical activity, such as weight training and stretching/flexibility exercise? \_\_\_\_\_

On average, how long is each exercise session? \_\_\_\_\_

8. Do you have any exercise equipment at home? YES NO If yes, please describe:

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**I have read the above questions and have answered them to the best of my knowledge.**

Signature \_\_\_\_\_ Date \_\_\_\_\_

Review by \_\_\_\_\_ Date \_\_\_\_\_

Comments \_\_\_\_\_