Health Profile

Guest Name: ______________________________ Birth Date: ______________ Gender: O M O F

We respect your unique health needs and concerns. If you require activity program modifications due to a medical condition or limitation, please let us know so a member of the staff can contact you.

Yes	No	
O	O	1. Has your doctor ever said that you have a heart condition and that you should only do physical activity recommended by a doctor?
O	O	2. Do you feel pain in your chest when you do physical activity?
O	O	3. In the past month, have you had chest pains when you were not doing physical activity?
O	O	4. Do you ever lose your balance because of dizziness or do you ever lose consciousness?
O	O	5. Do you have a bone or joint problems that could be made worse by a change in your physical activity?
O	O	6. Is your doctor currently prescribing drugs for high blood pressure or a heart condition?
O	O	7. Are you currently pregnant?
O	O	8. Have you had any major surgeries, injuries or illnesses in the past two years?
O	O	9. Do you have any other chronic conditions that we should be aware of?
O	O	10. Are you taking any medications that would affect your participation?
O	O	11. Do you know of any other reason why you should not do a physical activity?

If you answered yes to any of the above questions, please describe: ___________________________________

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NOTE: If you have food allergies, please tell your server(s).

Person to contact in case of emergency:

Name: ____ Phone Number: ____________________________

Smoking policy *– In the interest of health, Lake Austin Spa resort is a non-smoking facility. We ask that you please refrain from smoking inside any building, including your room. For your convenience, ashtrays can be provided for your use in your garden. To keep smoke from entering your room, please make sure all doors and windows are closed while you are smoking.* ***Removing smoke odors from a guest room following departure will result in a $1000 late charge for the Lady Bird Suite and a $500 late charge for all other rooms.*** *We appreciate your cooperation.*

I, the undersigned, affirm that the above information is true to the best of my knowledge. I further affirm that I have disclosed all medical information and am able to participate in an active program.

Signed: ____ Date: _____________________________