



# LAKESHORE

## Veteran Membership Application

Member # \_\_\_\_\_

Date (MM/DD/YYYY) \_\_\_\_\_

First Name Mr. Mrs. Ms. \_\_\_\_\_ Middle Initial \_\_\_\_\_ Last Name \_\_\_\_\_

Date of Birth (MM/DD/YYYY) \_\_\_\_\_ Age \_\_\_\_\_ Male Female Non-binary

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_ Cell \_\_\_\_\_ Home Email \_\_\_\_\_

County Jefferson Shelby Blount St. Clair Tuscaloosa Walker Other \_\_\_\_\_

Race/Ethnicity Asian/Pacific Islander Black/African American Hispanic/Latino  
White/Caucasian Native American Other \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Relation \_\_\_\_\_ Phone \_\_\_\_\_

Branch Served \_\_\_\_\_ # of Years Served \_\_\_\_\_

Do you have a service-connected disability? Yes No

*To qualify for our veteran membership, you must provide a copy of your DD-214 or your Military ID.*

How did you hear about Lakeshore's Veteran Membership? Internet Social Media News/TV  
Physician Friend/Fellow Veteran Lakeshore Staff Member Other \_\_\_\_\_

Primary Disability or Health Condition (if applicable) \_\_\_\_\_

Primary Care Physician \_\_\_\_\_ Clinic Name \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

### Membership Package

Premier - Access to Lakeshore Online Fitness, Lakeshore facility, classes and programs, including the aquatics center & aquatics classes

### Additional Individuals on Membership

*The Veteran Membership is applicable to the veteran and any individuals who live in the same household. Proof of residence for additional individuals is required.*

Name \_\_\_\_\_ DOB \_\_\_\_\_ Disability (if applicable) \_\_\_\_\_

Name \_\_\_\_\_ DOB \_\_\_\_\_ Disability (if applicable) \_\_\_\_\_

Name \_\_\_\_\_ DOB \_\_\_\_\_ Disability (if applicable) \_\_\_\_\_

Name \_\_\_\_\_ DOB \_\_\_\_\_ Disability (if applicable) \_\_\_\_\_

## Functional Ability Classification Questions

Name: \_\_\_\_\_

### Vision

Do you have difficulty seeing, even if wearing glasses?

- No difficulty
- Some difficulty
- A lot of difficulty
- Cannot do at all
- Prefer not to say
- Don't know

### Hearing

Do you have difficulty hearing, even if using a hearing aid(s)?

- No difficulty
- Some difficulty
- A lot of difficulty
- Cannot do at all
- Prefer not to say
- Don't know

### Mobility

Do you have difficulty walking or climbing steps?

- No difficulty
- Some difficulty
- A lot of difficulty
- Cannot do at all
- Prefer not to say
- Don't know

### Cognition (Remembering)

Do you have difficulty remembering or concentrating?

- No difficulty
- Some difficulty
- A lot of difficulty
- Cannot do at all
- Prefer not to say
- Don't know

### Self-care

Do you have difficulty with self-care, such as washing all over or dressing?

- No difficulty
- Some difficulty
- A lot of difficulty
- Cannot do at all
- Prefer not to say
- Don't know

### Communication

Using your usual language, do you have difficulty communicating, for example understanding or being understood?

- No difficulty
- Some difficulty
- A lot of difficulty
- Cannot do at all
- Prefer not to say
- Don't know



Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

### Readiness Questionnaire

This questionnaire will help us guide you to programs that may be most appropriate for you. Before becoming more physically active or if your health changes, we encourage you to speak to your doctor about any recommendations, contraindications, physical limitations or restrictions you may have.

		YES	NO
1.	Has your doctor ever said that you should only do medically supervised physical activity?	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2.	Are you currently going to physical therapy or have active physical therapy orders from a physician?	<input type="checkbox"/>	<input type="checkbox"/>
3.	Do you currently have or have had any bone or joint problems, or orthopedic surgeries that might limit you from engaging in physical activity?	<input type="checkbox"/>	<input type="checkbox"/>
4.	Do you have arthritis, osteoporosis, or back problems?	<input type="checkbox"/>	<input type="checkbox"/>
5.	Do you currently have cancer of any kind? If yes, please specify.	<input type="checkbox"/>	<input type="checkbox"/>
6.	Do you have a heart or cardiovascular condition? (i.e. Coronary Artery Disease, Heart Failure, or a diagnosed heart rhythm abnormality)	<input type="checkbox"/>	<input type="checkbox"/>
7.	Do you currently have high blood pressure? If yes, do you have difficulty managing your condition with medication or other physician-prescribed treatments? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>
8.	Do you have any metabolic conditions? (i.e. Diabetes or pre-diabetes, chronic kidney disease or liver problems). If yes, do you have difficulty managing your condition with medication or other physician-prescribed treatments? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>
9.	Do you have a respiratory disease? (i.e. Chronic Obstructive Pulmonary Disease, Asthma, Pulmonary High Blood Pressure, Emphysema) If yes, please specify.	<input type="checkbox"/>	<input type="checkbox"/>
10.	Do you have a spinal cord injury? If yes, do you have <input type="checkbox"/> paraplegia or <input type="checkbox"/> quadriplegia? Date of injury: _____	<input type="checkbox"/>	<input type="checkbox"/>
11.	Have you had a stroke? If yes, how affected? Date of injury: _____	<input type="checkbox"/>	<input type="checkbox"/>

		YES	NO
12.	Do you use a mobility device to get around inside the home or in the community? If yes, what type of device? <input type="checkbox"/> Manual Wheelchair <input type="checkbox"/> Power Wheelchair <input type="checkbox"/> Walker/Rollator <input type="checkbox"/> Cane/Crutches <input type="checkbox"/> Other	<input type="checkbox"/>	<input type="checkbox"/>
13.	Do you have any other medical condition not listed above? If yes, please check the box(es) below that apply to your health.	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> Amputation Type: _____ Prosthesis: <input type="checkbox"/> Yes <input type="checkbox"/> No		
	<input type="checkbox"/> Ankylosing Spondylitis <input type="checkbox"/> Ataxia		
	<input type="checkbox"/> Blind or Low Vision - Requires assistance with community mobility: <input type="checkbox"/> Yes <input type="checkbox"/> No		
	<input type="checkbox"/> Cerebral Palsy		
	<input type="checkbox"/> Epilepsy or Seizure Disorder If yes, have you had a seizure in the past 6 months? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	<input type="checkbox"/> Head Injury - Date of Onset: _____		
	<input type="checkbox"/> Lymphedema <input type="checkbox"/> Morbid Obesity		
	<input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Muscular Dystrophy		
	<input type="checkbox"/> Neuropathy <input type="checkbox"/> Osteogenesis Imperfecta		
	<input type="checkbox"/> Parkinson's Disease <input type="checkbox"/> Post-Polio Syndrome		
	<input type="checkbox"/> Spina Bifida <input type="checkbox"/> Spinal Muscular Atrophy		
	<input type="checkbox"/> Other Not Listed – Specify: _____		
14.	Do any of the following apply to you: <input type="checkbox"/> Incontinence of bowel or bladder <input type="checkbox"/> Current pressure sore(s) <input type="checkbox"/> On a bowel management program <input type="checkbox"/> Current open wound(s) <input type="checkbox"/> History of gastrointestinal (GI) issues such as irritable bowel syndrome (IBS), C-Diff, Chron's, Colitis, etc.		
15.	In case of emergency, is there any information you would want shared with emergency personnel? (i.e. allergies, hospital preference)		
16.	Are you comfortable using the aquatics center independently and safely?	<input type="checkbox"/>	<input type="checkbox"/>
17.	Are you comfortable using the fitness center equipment independently and safely?	<input type="checkbox"/>	<input type="checkbox"/>
18.	Do you prefer to have a one-time complimentary session to get you started?	<input type="checkbox"/>	<input type="checkbox"/>
19.	If yes, in what area(s)? <input type="checkbox"/> Aquatics Center <input type="checkbox"/> Fitness Center <input type="checkbox"/> Both		
20.	Are you interested in meeting with someone from the Recreation and Athletics department to learn more about programs offered?	<input type="checkbox"/>	<input type="checkbox"/>

I have fully read, understood, and completed this questionnaire. I agree that I have been encouraged by the Lakeshore Foundation staff to seek advice from my doctor before becoming more physically active, or if my health changes.

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

Date: \_\_\_\_\_