



# WOODSON YMCA POWER PLATE INTAKE FORM

FOR YOUTH DEVELOPMENT®  
FOR HEALTHY LIVING  
FOR SOCIAL RESPONSIBILITY

**Participant Name**

**Date**

PARTICIPANT PHONE NUMBER

EMAIL	DATE OF BIRTH
EMERGENCY CONTACT NAME	EMERGENCY CONTACT PHONE NUMBER

## What are your goals for using the vibration plates?

- Improve Circulation/Lymphatic Drainage
- Increase Flexibility/Mobility
- Improve Balance/Stability
- Core Strengthening
- Reduce Muscle Soreness/Stiffness
- Bone Health Support
- Other: \_\_\_\_\_
- Improve Posture
- Stress Reduction/Relaxation
- General Strength Training /Low Impact Exercise
- Warm-Up Before Exercise
- Improve Athletic Performance

## Health History & Contraindications

Select all that apply:

- High Blood Pressure
- Heart Disease or Heart Condition
- Pacemaker or Implanted Medical Device
- History of Stroke
- Hernia
- Severe Migraines
- Joint Replacement
- Osteoporosis
- Chronic Back Pain
- Undergoing Cancer Treatment
- Kidney Stones/Gallstones
- Hearing Aids
- Dizziness or Vertigo
- Epilepsy or Seizure Disorder
- Circulation Problems
- Diabetes
- Recent Surgery
- Severe Arthritis
- Acute Inflammation
- Recent Fracture or Injury
- Disk Issues or Herniation
- Pregnancy
- Detached Retina/Vibration Sensitive Eye Conditions
- Open Wounds or Recent Stitches

Additional Medical Conditions or Concerns: \_\_\_\_\_

## Current Activity Level

Please Circle One:      **Sedentary**      **Lightly Active**      **Moderately Active**      **Very Active**

Current Exercise Routine: \_\_\_\_\_

## Initial Visit & Participation Form

I understand that Whole Body Vibration Exercise may not be appropriate for all individuals. I affirm that the information provided above is accurate to the best of my knowledge. I understand it is my responsibility to consult my physician regarding participation if I have any medical concerns or conditions.

I understand that I should immediately stop participation and notify staff if I experience pain, dizziness, nausea, shortness of breath, chest pain, or discomfort during use.

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

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

Please complete all sections of this form and return the completed document via email to the instructor: Kolby Kleinschmidt 17kokleinschmidt@gmail.com

Staff Initial: \_\_\_\_\_

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

