BODY Structure
MEDICAL FITNESS FACILITY

Name_____ **Date**_____/_____/____

Address_____ **City, State, Zip** _____

Date of Birth _____ **Cell Phone**_____ **Work Phone**_____

E-mail Address_____

Emergency Contact_____ **Phone**_____

Height_____ **Weight**_____ **Age**_____ **Physician**_____

Whom May We Thank for Referring You? _____

What Is the Primary Reason for Your Visit? _____
Notes:

Consent/ Release for Participation and Information

The use of the facilities at Body Structure naturally involves the risks of injury to you, whether you are someone else cause it. As such, you understand and voluntarily accept this risk and agree Body Structure will not be liable for any injury, including without limitation, personal, bodily, or mental injury, economic loss or any damage to you, your spouse, unborn child, or relatives resulting from negligence or other acts of Body Structure or anyone else using the facilities. If there is any claim by anyone based on any injury, loss, or damage described here, which involves you, you agree (1) defend Body Structure against such claims and pay Body Structure for all expenses relating to the Claims (2) indemnify Body Structure for all liabilities to you, your spouse, unborn child, or relatives or anyone else resulting from such claims. Further you represent that you are in good physical condition and have no medical reason, impairment, or disability that might prevent you from using all Body Structure facilities. As such, you acknowledge that Body Structure did not give you medical advice before you joined, and cannot give you any after you join, relating to your physical condition and ability to use facilities. If you have any health or medical concerns now or after you join, discuss them with your doctor before using the facilities. If there is a dispute over $250 between you and Body Structure, both parties agree to submit it to binding arbitration under the rules of and before the American Arbitration Association and its office nearest to the club you used. The dispute covers and aspect related to your workouts or this Agreement, which includes, without limitation, financial obligations, facilities, representation, property damage, and injuries. Arbitration means that neither you nor Body Structure can sue each other in court over such disputes. You both agree to have a neutral arbitrator decide it, not a jury or judge.

I also hereby consent to release my information to my primary care physician. **Initials:**_____

Signature: _____ **Staff Signature:**_____

Patient:
Date:

Do vou have a historv of:	SELF	FAMILY
Diabetes**	Y ☐ N ☐	Y ☐ N ☐
Chest Pain*	Y ☐ N ☐	Y ☐ N ☐
High Blood Pressure*	Y ☐ N ☐	Y ☐ N ☐
Stroke***	Y ☐ N ☐	Y ☐ N ☐
Heart Attack**	Y ☐ N ☐	Y ☐ N ☐
Heart Disease***	Y ☐ N ☐	Y ☐ N ☐
Pacemaker/Defibrillator	Y ☐ N ☐	Y ☐ N ☐
High Blood Cholesterol	Y ☐ N ☐	Y ☐ N ☐
Kidney Disease**	Y ☐ N ☐	Y ☐ N ☐
Smoking*	Y ☐ N ☐	
Lung Disease	Y ☐ N ☐	
Are you or could you be pregnant?	Y ☐ N ☐	
Dizziness/Fainting*	Y ☐ N ☐	
Shortness of Breath*	Y ☐ N ☐	
Night Coughing	Y ☐ N ☐	
Headaches	Y ☐ N ☐	
Cancer	Y ☐ N ☐	
Osteoporosis	Y ☐ N ☐	Y ☐ N ☐
Osteoarthritis	Y ☐ N ☐	Y ☐ N ☐
Rheumatoid Arthritis	Y ☐ N ☐	Y ☐ N ☐
Rheumatic Disease	Y ☐ N ☐	
Alcohol Use		
↳ Drinks per Day/Week _____		
Allergies	_____	
Type	Y ☐ N ☐	
↳ Asthma	_____	
	Y ☐ N ☐	
Always have inhaler w/ you	_____	
Childhood Diseases	Y ☐ N ☐	
STDs	Y ☐ N ☐	
Seizures	Y ☐ N ☐	
Assistive Device (cane, etc.)	Y ☐ N ☐	
Eating Disorder	Y ☐ N ☐	

In the past month, have you frequently been bothered by feeling down, depressed, or hopeless?

In the past month, have you frequently been bothered with having little interest in the things you enjoy, or have you lost pleasure in doing things?

What does your current activity level consist of?

Please list or provide a copy of your current medications:

Have you had any falls within the last year? How many?
_____

Please list any major injuries or surgeries in your past:
Any other pertinent information that you think we should know?

How would you rate your quality of sleep?
(**1**…NOT GOOD AT ALL, **5**…. EXCELLENT) _____
Hours of sleep on average per night _____

How would you rate your stress level in general?
(**1**…NOT STRESSED AT ALL, **5**...VERY STRESSED) _____

How ready or able are you feeling about making any changes to your daily habits?
(**1**…NOT READY AT ALL, **5**…. READY TO GO) _____

Health Goals/Background

What is your ultimate motivation/reason for showing up for yourself here?

Why is this important to you? What does it mean for you to accomplish this goal? (Please be in depth as possible.)

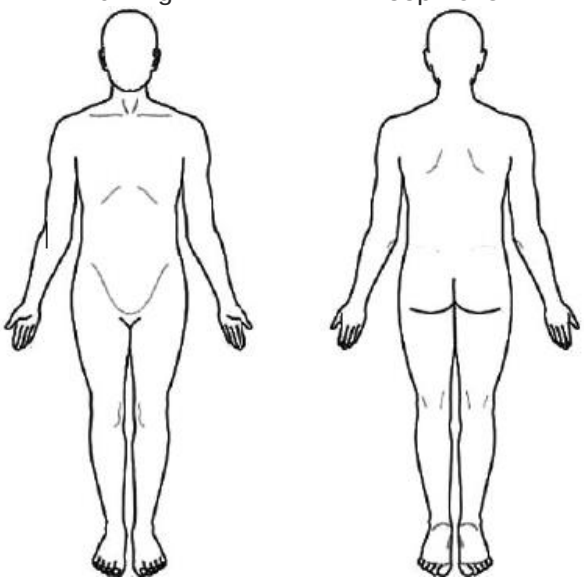
How do you envision your life changing as you reach this goal?

Patient/Representative Signature:_____Therapist Signature: _____

Patient:
Date:

Using the diagram below please indicate where you feel symptoms

KEY: Pins & Needles= 0000 Stabbing = ////
Burning = XXXX Deep Ache = *IIII*



Pain Rating: Please mark ***Best (BJ, Current (CJ), and Worst (W) levels of pain below***

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
0 1 2 3 4 5 6 7 8 9 10

(**0**= NONE to **10**= WORST Imaginable)

What makes your symptoms worse?

_____

What makes your symptoms better?

_____

How is your sleep at night?
☐ Fine ☐ Moderate difficulty ☐ Only with Medication

When(date) did your problem begin? _____

Have you been treated for this before?
Please elaborate:
_____

PATIENT SPECIFIC FUNCTIONAL SCALE

Please list three (3) activities that you are having difficulty with or would like to perform better. Please rate your ability for each activity.

0 = Unable to perform → 10 = No difficulty

1. _____ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
0 1 2 3 4 5 6 7 8 9 10

2. _____ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
0 1 2 3 4 5 6 7 8 9 10

3. _____ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
0 1 2 3 4 5 6 7 8 9 10

Other Relevant Information?

Back Ext, Leg Press, Leg Curl, Leg Ext, Low Back Row, Lat Pull Down, Chest Press

Pec Chest Flys, Shoulder Press, Hip ABD, Hip ADD

Patient/Representative Signature:_____ Date: _____

Therapist / Reviewer Signature:_____ Date: _____

Patient:
Date:

Consent and Authorization Release Form

Cancellation/Rescheduling Policies:

Welcome to Body Structure Clinic. Our goal is to provide you with the highest quality physical therapy care available. We must strongly emphasize the importance of patient compliance and responsibility in abiding by the recommended treatment. You must notify us by 7pm the day before your appointment if you need to reschedule. Not showing or canceling your appointment after 7pm ofthe day before will result in a $50.00 fee. If you call on the same day of your appointment and are able to reschedule your appointment on that same day (if available) our system will not charge the cancelation fee.

Initial: _____

Consent for Treatment:

I, _____, hereby give my permission for Body Structure Clinic to render treatment to me/my dependent. I understand that I will be given all available pertinent information prior to the treatment being rendered. I will be given the opportunity to ask questions and have them answered to my satisfaction. II understand that I may decline recommended treatment at any time, but if I choose to do so it is at my own medical risk.

Signature: _____ ***Date:*** _____

Consent for Massage:

I have been advised of all the policies and procedures pertaining to massage, benefits and contraindications of massage, and possible alternative therapies. I understand that the purpose of massage is to assist in reducing stress, relieving muscular tension/spasm/pain, and increasing circulation. If I experience any pain or discomfort, I will immediately inform the therapist so that the pressure or methods used can be adjusted to my comfort level. I understand that massage therapists do not diagnose illness or disease, prescribe any medical treatments, nor do they perform spinal manipulation, and nothing said or done during the session should be constructed as such. I acknowledge that massage is not a substitute for medical examinations or diagnosis, and I should see a health care provider for those services. Because massage should not be performed under some circumstances, I agree to keep the massage therapist updated as to any changes in my health, and I release the massage therapist and Body Structure Medical Fitness from any liability if I fail to do so.

Signature: _____ ***Date:*** _____

Consent to Release/Obtain Medical Information:

I, _____, hereby grant to Body Structure Clinic permission to release my personal and treatment information to my insurance company, employer, attorney, worker compensation carrier, physician/facility referred to for further treatment, and/or my referring/family physician. Permission is hereby granted to any and all other facilities where I have previously been treated to release medical records/x-rays to Body Structure Clinic.

Signature: _____ ***Date:*** _____

Authorization for Payment of Benefits for Insurance Covered Services:

I, _____, authorize insurance payment benefits to Body Structure Clinic for services rendered. Insurance checks and explanations of benefits sent to you for our services must be brought to us. The checks will be applied to your balance and the explanation of benefits will be copied and returned. I understand that any and all charges not paid by my insurance company are my sole responsibility and are due and payable by me.

Signature: _____ ***Date:*** _____

Privacy Policy

I *acknowledge that the Notice of Privacy Practice is posted at the location in which I am receiving treatment and that I have read and understand the notice. I further acknowledge that I have the rightto request a copy and one will be provided to me.*

Signature: _____ ***Date:*** _____

Child Liability:

I, _____, understand that Body Structure Clinic will not be held responsible for thesafety or welfare of any child left in the waiting room, or leaves the waiting room. It is my sole responsibility to provide appropriate supervision to any minors I bring into the facility.

Signature: _____ ***Date:*** _____