



Pre-Test Screening Form

Please Circle or Mark The Appropriate Response

PERSONAL DETAILS

Date: _____

Name: _____ Date of birth: _____ Weight: _____

Street _____ City _____ State _____ Zip _____

Primary phone: _____

In case of emergency, whom may we contact?

Name: _____ Relationship: _____

Phone: _____

MEDICAL HISTORY

How long since your last medical check up? _____

Are you taking any prescribed medication? **YES/NO** If yes, please list

Have you had any major injuries/surgery? **YES/NO** If yes, please list

Are you currently experiencing any pain? **YES/NO** If so, where? _____

PLEASE CHECK IF YOU HAVE, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING:

- Diabetes
- Chest Pain/Angina
- Heart Disease
- High Blood Pressure
- Heart Attack
- Pacemaker
- Vascular Disease
- CVA/Stroke/TIA
- Seizures
- Skin Abnormalities
- Nausea/Vomiting
- COPD
- Thyroid Problems
- Osteoporosis/Osteopenia
- Arthritis

- Hernia
- Recent Fractures
- Headaches
- Dizziness/Fainting
- Liver/Gallbladder Problems
- Kidney Problems
- Bowel/Bladder Problems
- Metal Implants
- Ringing in your Ears
- MRSA
- HIV
- Hepatitis
- Asthma
- Depression
- Anxiety

- Allergies: _____
- Cancer: _____
- Other: _____

Are you Pregnant?

Yes No

Do you smoke?

Yes No

ACTIVITY HISTORY

How were you referred to this program?

Why are you enrolling in this program?

Do you participate in a regular exercise program at this time? Yes ___ No ___ If yes, briefly describe:

Have you ever performed resistance training exercises in the past? Yes ___ No ___

Do you have injuries (bone or muscle disabilities) that may interfere with exercising? Yes ___ No ___
If yes, briefly describe:

What sports do you participate in?

What are your personal health and fitness objectives?

- _____
- _____
- _____
- _____

BIODEX FITNESS AND ATHLETIC PERFORMANCE TESTING RELEASE FORM

You have agreed to participate in OrthoCare Physical Therapy's Biodex fitness and athletic performance testing program, developed for functional assessment, movement and strengthening of the body. By signing below, you acknowledge and agree to the following: You represent that you are physically fit to participate in the session and that, prior to participation in the session, you have consulted a physician regarding any limitations or medical risks that you may have in relation to the session and certified that you are free from any such limitations and medical risks. You further understand and agree that the sessions involve physical exertions and strenuous physical activity by you, which entails certain risks and serious bodily injury and/or death, may occur. For example, physical contact with other participants, equipment or surfaces may occur during the sessions. With full knowledge of the risks, you voluntarily choose to participate in the test and (i) hereby forever release, covenant not to sue, discharge and waive all liability of OrthoCare Physical Therapy, its employees, volunteers, and owners for any bodily injury of any kind, suffered by you as a result of your participation in the sessions, regardless of whether such bodily injury was due to negligence of any kind commended by a physical therapist or otherwise, (ii) agree to indemnify and hold harmless OrthoCare Physical Therapy from any loss, liability or cost they may incur arising out of or related to your participation in the test, and (iii) assume full responsibility for any bodily injury, or property damage, arising out of or related to your participation in the test. Notwithstanding your agreement not to sue OrthoCare Physical Therapy, you agree that any legal proceedings of any kind, including those related to the enforceability of this waiver, shall take place in Roseville, Michigan, and shall be considered solely under the laws of the State of Michigan (without regard to principles of conflicts of law). **You certify that you have read the forgoing and understand that by signing below, are giving up certain legal rights and remedies and intend that your signature be a complete and unconditional release of all liability of OrthoCare Physical Therapy to the greatest extent permitted by law.**

AGREED AND ACCEPTED:

Participant's Signature: _____ Date: _____

Parent or Guardian's Signature (if under age 18): _____

Parent or Guardian's Name (if under age 18): _____

Parent or Guardian's Phone Number (if under age 18): _____