MOVEMENT CLINIC Chiropractic Sports Medicine Rehabilitation

# Performance Evaluation & Training

## Health History

Date: _____

Name: _____ Date of Birth: _____

Address: _____

Phone: _____ E-mail: _____

**Emergency Contact**

Name: _____ Relationship: _____

Phone: _____ Phone: _____

**Primary Care Provider**

Name: _____ City/State: _____

Date of last physical examination: _____

## Present/Past Health History

- ☐ Concussion
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Anemia
- ☐ Seizures
- ☐ Fainting or dizziness
- ☐ Shortness of breath
- ☐ Chest pain
- ☐ Heart palpitations
- ☐ Increased heart rate
- ☐ Known heart murmur
- ☐ Unusual fatigue
- ☐ Cancer
- ☐ Asthma
- ☐ Diabetes
- ☐ Spine injury
- ☐ Extremity injury
- ☐ Other:

**Comments**:

## Family Health History

- ☐ Heart attack
- ☐ Congenital heart condition
- ☐ High blood pressure
- ☐ Diabetes
- ☐ Cancer
- ☐ Other major illnesses or conditions

**Comments**:

## Surgical History

_____

_____

## Medications

_____

_____

## Activity History

1. Why are you interested in this program?

   _____

   _____

2. Do you currently participate in regular exercise? If so, what and how often? List all sports that you currently, or plan to participate in.

   _____

   _____

   _____

3. Do you have injuries, past or present, that may interfere with exercising?

   _____

   _____

4. Have you participated in any personal training programs in the past?

   _____

5. List in order your personal objectives or goals for this training program.

   a. _____

   b. _____

   c. _____

*Staff Use Only*

*Height:*_____ *Weight:*_____ *Pulse:*_____ *BP:*_____ *O2:*_____

# Physical Activity Readiness Questionnaire (PAR-Q)

The PAR-Q is designed to help you assess your level of readiness for physical activity (ages 15 to 69).

Please read the following questions carefully and check the appropriate box with your answer.

| YES | NO | | |
|---|---|---|---|
| ☐ | ☐ | 1. | **Has your doctor ever said that you have a heart condition and that you should only do physical activity recommended by a doctor?** |
| ☐ | ☐ | 2. | **Do you feel pain in your chest when you do physical activity?** |
| ☐ | ☐ | 3. | **In the past month, have you had chest pain when you were not doing physical activity?** |
| ☐ | ☐ | 4. | **Do you lose your balance because of dizziness or do you ever lose consciousness?** |
| ☐ | ☐ | 5. | **Do you have a bone or joint problem (for example, back, knee or hip) that could be made worse by a change in your physical activity?** |
| ☐ | ☐ | 6. | **Is your doctor currently prescribing drugs (for example, water pills) for your blood pressure or heart condition?** |
| ☐ | ☐ | 7. | **Do you know of any other reason why you should not do physical activity?** |

**If you answered NO** to all the questions you have reasonable assurance of your stability to begin an exercise program.

**If you answered YES to one or more questions**, we encourage you to consult with your primary care provider before beginning an exercise activity.

☐ I wish to begin participation immediately and understand that all physical activity and use of the facility shall be undertaken by me, or my dependent, at my sole risk.

_____ _____

Client or Authorized Representative (*Signature*) Relationship to Client

_____ _____

Client Name (*Printed*) Date

_____ _____

Staff or Contractor (*Signature*) Date

# Performance Evaluation & Training

# Consent & Policies

## Purpose and Explanation of Procedures

Physical and functional evaluation and exercise prescription may involve bending, twisting, and physically challenging joints and soft tissues (e.g. muscles and ligaments) of the spine and extremities and challenging the respiratory and cardiovascular systems for the purposes of improved physical performance and injury prevention.

I, the undersigned, understand and have been informed that there exists the remote possibility during exercise of adverse changes including, but not limited to, abnormal blood pressure, fainting, dizziness, disorders of heart rhythm, and in very rare instances heart attack, stroke, or even death. I further understand and I have been informed that there exists the risk of bodily injury including, but not limited to, injuries to the muscles, ligaments, tendons, and joints of the body. Every effort, I have been told, will be made to minimize these occurrences by proper staff or contractor assessments of my condition before each training session, staff or contractor supervision during exercise, and by my own careful control of exercise efforts. I fully understand the risks associated with exercise, including the risk of bodily injury, heart attack, stroke or even death, but knowing these risks, it is my desire to participate as herein indicated.

I have been informed that during my participation in the above described performance training program, I will be asked to complete the physical activities unless symptoms such as fatigue, shortness of breath, chest discomfort or similar occurrences appear. At this point, I have been advised that it is my complete right to decrease or stop exercise and that it is my obligation to inform the professional of my symptoms, should any develop.

I also understand that during the performance of my personal training program, physical touching and positioning of my body may be necessary to assess my muscular and bodily reactions to specific exercises, as well as to ensure that I am using proper technique and body alignment. I expressly consent to the physical contact for the stated reasons above.

Before I, or my dependent, engage in any activity, I will complete a health history to determine the risk of participating in exercise. If the health history, physical activity readiness questionnaire, or evaluation indicates that I should see my primary care provider before exercising, no further activity will be performed until that has occurred, unless I consent to do so with that knowledge.

I hereby voluntarily consent to the rendering of such activities, and am personally unaware of any injury, condition, or disorder that may complicate or prevent such activities.

I wish to rely on the staff or contractor of the Movement Clinic to exercise their best professional judgment during the limited course and scope of the performance examination and corrective exercise prescription provided in which the staff or contractor feels are in my best interest, based upon the facts as then known at the time. It is understood that no provider/patient relationship has been established, and the purposes of such examinations and assigned exercises are for performance purposes only.

## Confidentiality

I have been informed that the information which is obtained in this training program will be treated as privileged and confidential and will consequently not be released or revealed to any person, unless required for medical or legal purposes. Any other information will be used only by the program staff or contractor to evaluate my exercise status or needs. My information may be entered into an online database for tracking and exercise prescription purposes via e-mail.

## Consent

**I, the undersigned, hereby acknowledge that no guarantees have been made to me as to the effect of such examinations or corrective exercise prescription on my performance or injury prevention expectations. I further understand that if I closely follow the program instructions, that I will likely improve my exercise capacity and fitness level after a period of 3-6 months.**

**I, the undersigned, waive and release and agree to hold harmless and indemnify the Movement Clinic, its employees, agents, contractors, officers and directors against any and all claims any way connected with my participation in an exercise program. This agreement is binding on my heirs, executors, administrators and assigns.**

**I, the undersigned, have read and understood the above consent and have had the opportunity to ask questions about its content and meaning, if so desired, which have been answered to my satisfaction, PRIOR TO MY SIGNING OF THIS CONSENT FORM.**

_____

**Signature (Client, Parent, or Guardian)**

_____ _____

**Print Name (Client)** **Date**

_____

**Date of Birth (Client)**

_____ _____

**Signature (Staff or Contractor)** **Date**

## Appointment Cancellation Policy

There is a 1-hour cancellation and no-show policy. Clients must notify the clinic more than 1-hour prior to cancelling an appointment. Failure to do so will result in the full expected fee for that session to be billed to the client or removed from the remaining sessions within a package.

Client Initial: _____

## Payment Policy

Payment is due at the time of service or when purchasing a pre-paid package. ***A check made payable to Fitness and Massage, LLC or Rachel Knepp and/or a credit or debit care are the only accepted form of payment when Rachel Knepp is performing the training sessions as an independent contractor***. Otherwise, credit card, debit card, or check made payable to Movement Clinic is acceptable. Pre-paid packages are non-refundable and are to be used within the calendar year of purchase. Any unused training sessions within a package are considered null and void.

Client Initial: _____

## Fee Schedule

- ☐ Initial Evaluation $120
- ☐ Follow-Up Evaluation $60
- ☐ 6 Sessions $120
- ☐ 9 Sessions $160
- ☐ 12 Sessions $180
- ☐ Sibling discount of $60 per session package, per each additional child. The siblings must attend the same training sessions. There will be no exceptions.

An initial evaluation includes at a minimum of FMS, Y-Balance, and FCS screening in addition to a customized exercise prescription. The follow-up evaluation includes the same methods to determine progress.

Client Initial: _____ Date of Purchase: _____