

Welcome to RPI! *We're so excited to begin this journey with you! To ensure we have the information we need to best serve you, please take a few moments to fill out the form below. Thank you!*

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## Client Information

FIRST NAME

MIDDLE INITIAL

LAST NAME

PREFERRED NAME

DATE OF BIRTH (MM/DD/YYYY)

HOW DID YOU HEAR ABOUT US?

GENDER

PREFERRED CONTACT METHOD:

M

F

Phone

E-mail

Text

HOME STREET ADDRESS 1

STREET ADDRESS 2

CITY

STATE

POSTAL CODE

EMAIL

PRIMARY PHONE NUMBER

WORK PHONE NUMBER

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## Emergency Contact

Name of Emergency Contact

Phone Number

Relationship

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**Medical Team** *We value being able to communicate effectively with all the members of your medical team. Please provide us with the names of the following providers so that we may strive to provide continuity of care.*

Family MD

Chiropractor

Orthopedic MD

Massage Therapist

Other

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# Health Screen

Please check the box next to the listed medical conditions you have or have had in the past.

- |                                      |  |
|--------------------------------------|--|
| Changes in bowel or bladder function | Weight loss/gain (circle one)                |
| Fever/ chills/ sweats                | Nausea/vomiting                              |
| Shortness of breath                  | Pain at night                                |
| Dizziness/ lightheadedness           | Headaches                                    |
| Weakness/fatigue                     | Difficulty maintaining balance while walking |
| Changes in appetite                  | Difficulty swallowing                        |
| Cancer (type and date) _____         | Heart disease                                |
| High blood pressure                  | Asthma                                       |
| Pacemaker inserted                   | Osteoporosis                                 |
| Alcoholism/ Drug use                 | Rheumatoid arthritis/ Osteoarthritis         |
| Stroke                               | Depression/ Anxiety                          |
| Anemia                               | Lung problems                                |
| Thyroid problems                     | Diabetes                                     |
| Neurological Conditions: _____       | Past concussions or TBI                      |
| Kidney/liver problems                | Stomach problems                             |
| Autoimmune Disorder                  | Other: _____                                 |

FOR WOMEN, are you currently pregnant or think you might be pregnant?

Yes      No

Height

Weight

Do you smoke?

Yes      No

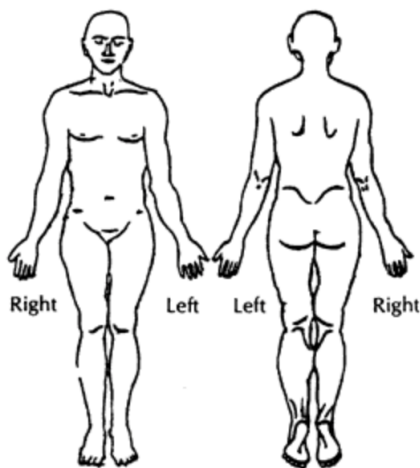
Do you currently exercise?

Yes      No

If yes, please list the time, intensity, and mode of exercise you perform.

Please indicate on the body diagram the area of your current pain or past problems. Please include any other pain that you experience in your body.

OOO= Numbness/ tinging , ZZZ= Deep aching , XXX= Burning , ///= Stabbing



**PLEASE RANK THE FOLLOWING ON THE PAIN SCALE 0= No pain, 10= Worst imaginable pain (take me to the ER)**

	0	1	2	3	4	5	6	7	8	9	10
Worst pain in the past 24 hours											
Current pain											
Best pain in the past 24 hours											

What are the goals you would like to achieve by attending the wellness classes?

Please list any additional questions, concerns, or issues you may have at this time.

**PLEASE READ AND SIGN THE RELEASE BELOW TO PARTICIPATE IN OUR CLASSES:**

I, \_\_\_\_\_, have enrolled in the wellness program offered by Rehabilitation & Performance Institute, PSC. I recognize that the program may involve strenuous physical activity including, but not limited to, muscle strength and endurance training, cardiovascular conditioning and training, and other various fitness activities. I hereby affirm that I am in good physical condition and do not suffer from any known disability or condition which would restrict my participation in this physical program. I have also informed my trainer regarding any current or past health limitations.

In addition, I am fully aware of the risks and hazards connected with the participation in the physical program including, but not limited to, physical injury or even death. I hereby elect to voluntarily participate in this program knowing that the associated physical activity may be hazardous to me and/or my property. I VOLUNTARILY ASSUME FULL RESPONSIBILITY FOR ANY RISKS OR LOSS, PROPERTY DAMAGE, OR PERSONAL INJURY, INCLUDING DEATH, THAT MAY BE SUSTAINED BY ME, OR LOSS OR DAMAGE TO PROPERTY OWNED BY ME, AS A RESULT OF PARTICIPATION IN THIS PROGRAM.

I hereby release, waive, discharge, and covenant not to sue Rehabilitation & Performance Institute, PSC and/or any of its officers, consultants, volunteers, and/or employees from any and all liability, claims, demands, actions, and causes of action whatsoever arising out of or related to any loss, damage, or injury that may be sustained by me, or to any property belonging to me, while participating in this program, or while on or upon the premises where the event is being conducted including, but not limited to, any claims arising under negligence.

It is my expressed intent that this waiver and release shall bind any and all members of my family including, but not limited to, my spouse, if I am alive, and my heirs, assigns, and personal representatives, if I am deceased. It is also my expressed intent that this waiver and release shall also be deemed a full release, waiver, discharge, and covenant not to sue insofar as my aforementioned family members, heirs, assigns, and personal representatives are concerned. I hereby further agree that this waiver and release shall be constructed in accordance with the laws of the State of Kentucky.

In signing this waiver and release, I acknowledge and represent that I have read and understand the foregoing and hereby sign it voluntarily as my own free act and deed; no oral representations, statements or inducements, apart from the foregoing written agreements have been made; and I hereby execute this waiver and release for valuable consideration, intending to be bound by the same.

SIGNED

DATE (MM/DD/YYYY)

IF UNDER THE AGE OF 18, PARENT MUST SIGN BELOW TO CONSENT TO ATTEND CLASSES

DATE (MM/DD/YYYY)