SECTION ONE - GENERAL INFORMATION:

1. Name:

2. Phone:

3. Email:

4. Mailing Address:

5. Emergency Contact:

Phone Number:

6. Gender (circle one): Female Male Not-specified

7. Date of Birth:

8. Height:

9. Weight

10. Number of hours worked per week (on average):

Less Than 20 20-40 41-60 Over 60

11. More than 25% of the time at your job is spent (check all that apply):

Sitting At Desk Lifting Standing Walking Driving

SECTION TWO - CURRENT MEDICAL INFORMATION:

1. Please list any medications taken within the last six months (check all that apply):

- Blood Thinner
- Epilepsy Medication
- Nitroglycerin
- Diabetic
- Heart Rhythm Medication
- Blood Pressure Medication
- Diuretic
- Insulin
- Other:

_____

2. Please list any surgeries or injuries in the last six months:

_____

_____

3. Please list any of these health symptoms that occur frequently (two or more times/month) requires medical attention (check any that apply):

- Swollen joints
- Abdominal pain
- Feel faint
- Low-back pain
- Leg Pain
- Dizziness
- Breathlessness with slight exertion
- Arm or shoulder pain
- Palpitation or fast heart beat
- Chest pain
- Unusual fatigue with normal activity
- Other:

_____

SECTION THREE - MEDICAL HISTORY:

1. Please check any of the following for which you have been diagnosed or treated by a physician or health professional (check all that apply:

- Diabetes
- Epilepsy
- Neck Strain
- Asthma (please check following option for inducing element)
    - allergy
    - exercise
    - n/a
- Obesity
- Back strain
- Rheumatoid arthritis
- Heart problems
- Stress
- Stroke
- Cancer
- High blood pressure
- HIV
- Concussion
- Hypoglycemia
- Other:

_____

2. Please list any operations you have had (check all that apply and give procedure title+ date):

Back:

- _____

Heart:

- _____

Kidney:

- _____

Eyes:

- _____

Joint:

- _____

Neck:

- _____

Ears:

- _____

Hernia:

- _____

Lung:

- _____

Other:

- _____

SECTION FOUR - HEALTH-RELATED BEHAVIORS

1. Have you ever smoked? Yes No
If so, when did you quit:

---

2. Do you now smoke? Yes No
If so, how many a day:

---

3. Do you exercise regularly? Yes No
If so, how many hours a week:

SECTION FIVE - HEALTH-RELATED ATTITUDES

1. How often do you experience “negative” stress from each of the following:

	Always	Usually	Frequently	Rarely	Never
Work:	_____	_____	_____	_____	____
Home or family :	_____	_____	_____	_____	____
Social pressure:	_____	_____	_____	_____	____
Personal health	_____	_____	_____	_____	____

2. List everything not included on this questionnaire that may cause you problems in a fitness assessment or fitness program:

Policies and Practices:

Appropriate clothing is to be worn at all times during assisted stretch session. Athletic apparel is required. Provider may decline providing service to client, at cost of client, if improper clothing is worn.

If client is late time will be deducted from session at client cost. If provider is late time will be added with no charge to session or clients charge will be reduced to reflect time of session given.

Clients are required to give twenty-four-hour notice for any cancelations. If a client cancels less than twenty-four hours prior to appointment, half of the full cost of service will be due in addition to regular cost at next scheduled service. Cancellations more than twenty-four hours prior to service will generate no financial debt. If client reschedules an appointment three consecutive times, the full cost of a service will be due in addition to regular cost at next service. Cancellation fee may be waived at discretion of service provider.

Client is required to inform provider of any changes in medical history between visits. There will be a six-week waiting period after all surgical procedures. There will be a one-week waiting period after illness for all clients.

Assisted stretch is a hands-on service. At times during service provider will have to place hands on; glutes, upper thigh, lower thigh, pectoral area, upper back, lower back, arms, hands, feet, etc. These do not include all areas that may be touched for pressure or leverage during service. Service providers will for no reason place hands on genital area, unclothed pectoral area or unclothed glutes. If, at any time client or provider are uncomfortable with hand placement or service, the right is maintained to end service and terminate any further professional relationship.

Providers, and all affiliates of Bisceop Wellness, retain the right to terminate any further professional relationship with clients for any reason.

bisceop

STRENGTHEN.NOURISH.EMPOWER

Purpose and Explanation of Service

I understand that the purpose of the assisted stretch program is to provide improved pliability, functionality and range of motion; through relief of daily compression and tension. A specific routine will be performed on me based on my needs and abilities. All exercise prescription components will comply with proper exercise program protocols. All programs are designed to place a gradually increasing flexibility on to the body.

Risks

I understand, and have been informed, that there exists the possibility of adverse changes when engaging in a physical activity program. I have been informed that these changes could include abnormal blood pressure, fainting, disorders of heart rhythm, stroke and very rare instances of heart attack or even death. I have been told that every effort will be made to minimize these occurrences by proper screening and by precautions and observations taken during the exercise session. I understand that there is a risk of injury, heart attack, or even death as a result of my participation in an exercise program, but knowing those risks, it is my desire to partake in the recommended activities.

Benefits

I understand that participation in an exercise program has many health-related benefits. These may include improvements in range of motion, flexibility, and functionality. I understand that the benefits outlined by my provider may take more than one session to attain; as well as require a continued session to keep.

Confidentiality and Use of Information

I have been informed that the information obtained in this exercise program will be treated as privileged and confidential and will consequently not be released or revealed to any person without my express (written or verbal) consent. Any other information obtained, however, will be used only by the program staff to evaluate my exercise status as needed.

Inquiries and Freedom of Consent

I have been given an opportunity to ask questions about the exercise program. I further understand that there are also other unknown health risks. Despite the fact that a complete accounting of all these remote risks has not been provided to me, I still desire to proceed with the exercise program. I acknowledge that I have read this document in its entirety or that it has been read to me if I have been unable to read. I consent to the rendition of all services and procedures as explained herein by all program personnel.

I (CLIENT) authorize the information I have given is truthful. I agree to the terms of this contract as well as the policies and procedures of Bisceop Wellness.

Print

Signature Date

I (PROVIDER) authorize that I have explained this information fully. I agree to the terms and conditions of this contract as well as the policies and procedures of Bisceop Wellness.

Anna R Bishop

Signature Date