INTEGRATED
PERFORMANCE TRAINING

Health Fitness Pre-participation Screening Questionnaire

Health History

Please mark with (Y) yes (N) no for these health history questions. Explain all "yes" answers in the space provided below

Physical Exam in the past 12 months	___	Mono (in the past year)	___
Any Health Concerns	___	Excessive weight loss/gain	___
Allergies to food or bee stings	___	Dental braces/bridges/caps	___
Allergies to medication	___	Concussion	___
Any other allergies	___	Fainting or blacking out	___
Any daily medications	___	Chest pain	___
Any problems with vision	___	Heart problems	___
Use contact lenses or glasses	___	High blood pressure	___
Any problems hearing	___	Bleeding more than expected	___
Any problems with speech	___	Problems breathing or coughing	___
Hospitalization or ER visits	___	Any smoking	___
Any broken bones or dislocations	___	Asthma treatment	___
Any muscle or joint injuries	___	Seizure treatment	___
Any neck or back injuries	___	Diabetes	___
Problems running	___	ADHD/ADD	___

Family History

Any relative ever have a sudden unexplained death (less than 50 years old) ___
Any immediate family member have high cholesterol ___

Please explain all "yes" answers here. Age at time of injury to be included.

_____
_____
_____
_____
_____

Current Medications (inhalers/epi-pens)

_____
_____
_____
_____
_____

_____ _____
Patient/Guardian/Responsible Party **Date**

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PARTICIPANT INFORMATION

Date: ___/___/_____

Last Name _____ First Name _____ Sex: Male/Female Date of Birth _____/_____/_____

Address _____ City, State & Zip _____

Home Telephone _____ Cell Telephone _____

Email: _____ How did you hear about us? _____

Person to Notify in Case of Emergency _____ Telephone _____

Consent

I _____ acknowledge that, by signing this document, I have voluntarily chosen to participate in a program of progressive physical exercise that can enhance the musculoskeletal and cardiorespiratory systems. In signing this document, I acknowledge being informed of the possible strenuous nature of the program and the potential for unusual, but possible physiological results including, but not limited to, abnormal blood pressure, fainting, heart attack or death. By signing this document, I assume all risk for my health and any resultant injury or mishap that may affect my well-being. I also agree to hold harmless of any responsibility, the instructor, facility or any persons involved with this program and testing procedures. I understand that questions about exercise procedures and recommendations are encouraged and welcomed.

_____ _____

Patient/Guardian/Responsible Party **Date**

Financial Policy

Group Classes/Camps:
I understand that payment for wellness programs is expected in advance. No refunds or credits will be given for missed or cancelled sessions.

One-on-One & Small Group Fitness Coaching:
Payment for the planned number of wellness sessions is expected in prior to participation. Sessions rescheduled less than 24 hours in advance of the scheduled time will result in forfeiture of the prepaid session. Prepaid fitness coaching sessions are refundable only with written documentation from a licensed physician indicating that you have become medically unable to utilize the remainder of your prepaid sessions.

_____ _____

Patient/Guardian/Responsible Party **Date**

Photo Release

I hereby give Integrated Rehabilitation Services (IRS) consent to photograph me and to edit, copy, display, distribute or publish these photos for the purposes of promoting their services in the community. I understand that any photo used will become the property of Integrated Rehabilitation Services. I also release all rights to photos for future promotion.

_____ _____

Parent/Guardian/Responsible Party **Date**