Past Medical History Form

Today's Date:	Last Name:	First Name:	Middle Init.	Gender
DOB:	Parent/Guardian Name(s):			

Home Address	Apt #	City	State	Zip Code

Home Telephone #	Cell Phone #	Email Address: ___ ☐ Check this box if you DO NOT want to be contacted via email regarding our services.

Emergency Contact Name and Relationship:	Telephone #

Goal of Program: ___

1. Have you had an injury before? Yes ☐ No ☐
If yes, please list your injuries (most recent first): ___

___

2. Have you ever had a surgery? Yes ☐ No ☐

If Yes, please specify type of surgery and date: ___

3. If you are female, is it possible you are pregnant? Yes ☐ No ☐

4. Do you have, or have you had, and of the following: Also consider during and/or after exercise:

Diabetes	Yes ☐	No ☐	Hypoglycemia	Yes ☐	No ☐	Fatigue	Yes ☐	No ☐
Chest Pain/Angina	Yes ☐	No ☐	Osteoarthritis	Yes ☐	No ☐	Fractures	Yes ☐	No ☐
High Blood Pressure	Yes ☐	No ☐	Osteoporosis	Yes ☐	No ☐	Surgeries	Yes ☐	No ☐
Heart Disease	Yes ☐	No ☐	Ringing in Ears	Yes ☐	No ☐	Smoking	Yes ☐	No ☐
Heart Attack	Yes ☐	No ☐	Seizures/Convulsions	Yes ☐	No ☐	Stroke	Yes ☐	No ☐
Heart Palpitations	Yes ☐	No ☐	Metal Implants	Yes ☐	No ☐	Cancer	Yes ☐	No ☐
Heart Murmur	Yes ☐	No ☐	Dizziness/Fainting	Yes ☐	No ☐	Pacemaker	Yes ☐	No ☐
Bowel/Bladder Dysfunction	Yes ☐	No ☐	Heat Related Illness	Yes ☐	No ☐	Hernia	Yes ☐	No ☐
Kidney Problems	Yes ☐	No ☐	Urine Leakage	Yes ☐	No ☐	Viral Infection	Yes ☐	No ☐
Asthma/Breathing Problems	Yes ☐	No ☐	Skin Abnormalities	Yes ☐	No ☐	Sickle Cell	Yes ☐	No ☐
Liver/Gallbladder Problems	Yes ☐	No ☐	Concussion	Yes ☐	No ☐	Headaches	Yes ☐	No ☐
Other	Yes ☐	No ☐						

If you answered **Yes** to any of the above items, please briefly explain and give the date(s). Include any other pertinent information regarding your past medical history: ___

___

5. Has any family member or relative died of heart problems and/or sudden death before age 35? Yes ☐ No ☐
6. Has a physician ever denied or restricted your participation in sports due to heart problems? Yes ☐ No ☐
7. Have you ever been told by a physician to restrict your activity or not to participate in a sport? Yes ☐ No ☐

Client Signature:___ Date: ___

Parent/Guardian Signature:___ Date: ___

Client Responsibilities

Our job at Bon Secours InMotion Physical Therapy and Sports Performance is to help you as the client(s) improve yourself. Our goal is to improve your game or lifestyle and design a program that will help you improve your overall performance and health so you can reach the next level. Our Sports Performance team includes the highest caliber professionals with advanced degreed Physical Therapists, Certified Athletic Trainers, and Certified Strength and Conditioning Specialists.

- To ensure we are aware of your arrival please sign in at the front desk prior to all sessions.
- To receive the most benefit from your sessions please refrain from using your cell phone.
- If you are running late please call to inform us so we can restructure your program for the most beneficial impact for the time remaining in your scheduled session. Your session will still end at the allotted scheduled time. Arriving 15 minutes late may result in the cancellation of your appointment.
- Please call ahead 24 hours in advance to cancel your appointments.
- If you happen to miss more than 2 appointments, and do not return our calls, your remaining appointments already scheduled will be removed.
- Sessions are not guaranteed to be 1-on-1, and your trainer may be assisting other clients within the same program during your session.
- If you are interested in 1:1 sessions talk to your trainer regarding pricing and scheduling.
- These responsibilities allow us to give you the best care during your sessions, if they are not followed it can result in:
  - Forfeiture of the session.
  - Potential termination of your remaining sessions depending on the severity of the issue(s).
- Please notify anyone from the sports performance department, the front office or another staff member if for some reason you are not satisfied with your sessions so that we may remedy the situation.
- All programs have time limitations, if you have questions about these limitations please ask the Sports Performance Coordinator to go over them with you.
- Please use good judgment regarding behavior and respect during your session. If improper behavior is noted, it is the Sports Performance staff's decision to terminate that session or the remaining sessions.

Refund / Cancellation Policy

- You are allowed 3 visits, and if not satisfied with the program you may receive a 75% refund. If you are seeking a refund for any reason it must be done within 48 hours after your 3rd visit.
- Exceptions to this policy may occur if you are physically unable to perform and continue the program. A physician note detailing this is **required** for a pro-rated refund based on the number of sessions attended. This can occur at anytime during the program, but the documentation must be presented to the clinic within 1 week.
- **Bariatric surgery** recipients are **excluded** from refunds.

Client Signature | Client Print

_______________ _______________ _______________

Date

(if under 18 years old)
Parent/Guardian Signature | Parent/Guardian Print

_______________ _______________ _______________

Date

Consent & Release of Liability

Sports Performance Program

Bon Secours In Motion Physical Therapy professionals are prepared to assist athletes in maintaining and enhancing athletic performance. Prior to participating in testing or training under our Sports Performance Program (the "Program"), you, as an athlete participating in the Program, and your parent or legal guardian, as your personal representative, must read, understand, and sign this consent. The Program consists of rigorous physical activity and specially designed exercise to enhance athletic performance.

1. Prior to training under the Program, you will undergo a sports injury screening which includes various evaluations of your anatomy, strength, flexibility and physical function. This initial sports injury screening includes muscle testing and certain training activities that may cause you to experience some muscle soreness.

2. Prior to commencing the Program, we strongly recommend that you have a physical examination performed by your primary care physician or your sports medicine physician within the past year that clears you for participation in the Program. You may begin the Program without such a physical examination; however, we ask that you specifically waive our recommendation by signing below.

3. We do reserve the right to deny your participation in the Program if we believe your participation may put you at risk of injury based on the results of the evaluation which will include history of your physical injuries and other health-related conditions, or based on our observations of your physical condition that arise during the course of training under the Program.

4. During the Program, you hereby acknowledge and agree that you will engage in rigorous physical activity and that there is a risk of physical injury, including death, associated with such activity.

5. By signing this document, you expressly: (a) represent that you are in good health and physical condition and are capable of full participation in the rigorous physical activity that is part of the Program; (b) agree to assume all risk of personal injury while attending and participating in the Program; (c) represent that you are signing on behalf yourself and your estate, heirs, representatives and assigns; and 4) release and indemnify and hold harmless Bon Secours DePaul Medical Center In Motion Physical Therapy and all of its employees, agents and affiliates from and against any and all losses or liability whatsoever for any accident or injury, fatal or otherwise, which may result directly or indirectly from your participation in this Program brought by you or on your behalf or by any third party.

6. **TESTIMONIAL AND MEDIA RELEASE:** By signing this document, I hereby authorize Bon Secours In Motion to use my name, photo, testimonial and any information in the testimonial in its marketing efforts. I understand and authorize the disclosure by In Motion of my name, photo or testimonial information in brochures, publications, websites, marketing materials and electronic communications. I waive the right of prior approval and hereby release In Motion from all claims for damages of any kind based on the use of my name, photo, testimonial or information in the testimonial.

IF YOU DO NOT CONSENT TO THE MEDIA RELEASE: _________________ (Initial Here)

7. IF PARTICIPANT IS UNDER 18 YEARS OLD: As the parent or guardian of the child participating in this program, by signing this document you expressly: (1) acknowledge and agree to the terms, conditions and representations within this Consent and Release of Liability on behalf of myself and my minor child; (2) consent to permit my minor child to participate in the Program; (3) acknowledge that this Consent and Release of Liability shall be binding upon all parents and legal guardians of the minor child, including their respective estates, heirs, representatives and assigns.

I am under the age of 18 and my parent/legal guardian is present at the time of this agreement reading and signing.

Participant Signature:_______________________________________ Date:_____________

Parent or Legal Guardian:____________________________________ Date:_____________