PARADIGM PHYSICAL THERAPY AND WELLNESS POLICY FOR PAYMENT SCHEDULE AND INITIAL GYM SET UP APPOINTMENT

_____ It is the policy of Paradigm Physical Therapy & Wellness that all payments for gym memberships will be due at the first of every month. Any customer wishing to join any time after the first of the month will be billed at a pro-rated rate of $10.00 per week for the remaining weeks in that month. **Membership fees are non-refundable**.

_____ It is the policy of Paradigm Physical Therapy & Wellness to collect $40.00 Regular /$30.00 SilverSneakers members to reserve an appointment with our Strength and Conditioning Specialist for your gym evaluation and two appointments thereafter to set up your initial fitness program.
This fee is non-refundable.

_____ **PT TRANSFERS ONLY** It is the policy of Paradigm Physical Therapy & Wellness to collect $20.00 to reserve three appointments with our Strength and Conditioning Specialist to initiate your personal fitness program. **This fee is non-refundable.**

A $35.00 FEE WILL BE ASSESSED FOR EVERY INSUFFICIENT FUND NOTICE WE RECEIVE FROM YOUR BANK

I have read the above policy and agree to these terms.

_____
Print your name

X_____ **X**_____
Signature Date

Paradigm Physical Therapy and Wellness
Facility Use Waiver

Participant Agreement

I understand and recognize that I may experience potential health risks, such as but not limited to, light headedness, nausea, dizziness, fainting, dehydration, muscle strain, back injury, or death by participating in the exercise programs, services, and facilities offered by Paradigm Physical Therapy and Wellness, and hereby assume full responsibility if such health risks occur. I am fully aware that it is my obligation to immediately inform the staff at Paradigm if I experience such health risks or any pain, discomfort, or any other abnormal symptoms that may occur during my participation. I understand that I may stop my participation of any activity if I so desire. I also understand that I may be requested to stop any activity by any staff member and must comply with this request, if the staff member observes symptoms of distress or other abnormal responses to exercise. I understand that staff members may include individuals who are not licensed, certified, or registered and acknowledge that their competencies and skills will vary according to experience and training.

I understand that Paradigm may request or require a physician release in order to participate in any of our programs. I acknowledge that if I have not obtained physician clearance to begin an exercise program, that I accept full responsibility for any adverse reactions from said program and that I am participating of my own free will and hereby release Paradigm Physical Therapy and Wellness from any and all claims.

Participant Rules

All participants in Paradigm Fitness programs agree to adhere to the rules and regulations as mandated by policy. I acknowledge that policies may change over time and that failure to comply with established policy may result in termination of membership.

I HAVE CAREFULLY READ, UNDERSTAND, AND AGREE TO ALL OF THE ABOVE.

Signature: _____ Date: _____

Signature of Parent: _____ Date: _____
(If participant is under the age of 18)

HEALTH STATUS QUESTIONNAIRE

SECTION 1. GENERAL INFORMATION

1. Date_____

2. Name_____

3. Mailing address_____ Phone (H)_____

   _____ Phone (W/C)_____

   Email _____ Subscribe to newsletter(its Free) ___Yes___No

4. Personal Physician_____ Phone_____

5. Person to contact in case of emergency_____ Phone_____

6. Gender (circle one): Female Male

7. Date of birth_____/_____/_____

8. Height_____ Weight_____

9. Number of hours worked per week: Less than 20 20-40 41-60 Over 60 Retired

10. More than 25% of the time at your job is spent (circle all that apply)
    Sitting at a desk Lifting loads Standing Walking Driving

SECTION 2 Wellness and Lifestyle INFORMATION

11. Reason for participating in a wellness program: Exercise Nutrition Stress Management Cont Rehab

12. List all medication taken in the last 6 months:
_____
_____

13. Please list any orthopedic conditions. Include any injuries in the last six months

    _____

14. Any of these health symptoms that occur frequently (two or more times/month)and **requires medical attention**. Please check any that applies.

    a. _____ Cough up blood
    b. _____ Abdominal pain
    c. _____ Low-back pain
    d. _____ Leg pain
    e. _____ Arm or shoulder pain
    f. _____ Chest pain
    g. _____ Swollen joints
    h. _____ Feel faint
    i. _____ Dizziness
    j. _____ Breathless with slight exertion
    k. _____ Palpitation or fast heart beat
    l. _____ Unusual fatigue with normal activity

Other_____

SECTION 3. MEDICAL HISTORY

15. Please circle any of the following for which you have been diagnosed or treated by a physician or health professional:

Alcoholism	Diabetes	Kidney Problem
Anemia, sickle cell	Emphysema	Mental illness
Anemia, other	Epilepsy	Neck strain
Asthma	Eye Problems	Obesity
Back strain	Gout	Phlebitis
Bleeding trait	Hearing loss	Rheumatoid arthritis
Bronchitis, chronic	Heart problems	Stress
Stroke	Cancer	High blood pressure
Thyroid problem	Cirrhosis	HIV
Ulcer	Concussion	Hypoglycemia
Congenital defect	Hyperlipidemia	Other_____

16. Circle any operation you have had:

Back	Heart	Kidney	Eyes	Joint	Neck
Ears	Hernia	Lung	Other_____		

17. Circle any who died of heart attack before age 50: Father Mother Brother Sister Grandparent

SECTION 4. HEALTH-RELATED BEHAVIORS

19. Have you ever smoked? Yes No

20. Do you currently smoke? Yes No

21. If you are a smoker, indicate the number smoked per day:

Cigarettes: 40 or more 20-39 10-19 1-9
Cigars or pipes only: 5 or more or any inhaled less than 5

22. Do you exercise regularly? Yes No

23. Last physical fitness test: _____

24. How many days a week do you accumulate 30 minutes of moderate activity?
0 1 2 3 4 5 6 7 days per week

25. How many days per week do you normally spend at least 20 minutes in vigorous exercise?
0 1 2 3 4 5 6 7 days per week

26. Weight now: _____ One year ago: _____ Age 21: _____

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

_____

_____

_____

How did you hear about our fitness/gym programs?

Silver Sneaker program:
Newspaper, Internet, etc_____
Physician _____
Friend _____
While here for Physical Therapy _____
Other Explain _____

Wellness and Gym programs:
Newspaper, Internet, etc_____
Physician _____
Friend _____
While here for Physical Therapy_____
Other Explain_____