Personal Information

Date:

Name:	Date of Birth: Age:
Home Address: City: State: Zip:	Preferred phone number: Is this number: □ home □ work □ mobile
Emergency Contact: Phone number: Relationship to client: Parent or Legal Guardian Name (if patient under 18):	Preferred email: Is this email: □ home □ work
Current marital status (check one): □ single □ married □ cohabitation □ widowed □ separated □divorced	Educational Background (check one) □ high school □ college □ grad school □ other:
Employer:	Occupation (check one): □ office □ factory □ farming □ driving □ student □ professional □ homemaker □ retired □ unemployed □ other:

How did you find out about our services? (please check all that apply)

___ Friend or training partner _____

___ Doctor or referring practitioner _____

___ South Congress Athletic Club

___ Smart Sport or Smart Life websites

___ Training group (I.e. Rogue Training Systems)

___ RunTex

___ Brochure or flyer

___ Current Smart Sport client – name: _____

___ Other _____

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Medical History

Height: _____ Current Weight _____ Goal Weight _____

Are you currently experiencing any health problems or under the care of a physician for any condition? If yes, please note the current problems below.	Y	N
Has a physician ever prescribed any limitations to exercise? If yes, for what reason?	Y	N
Have you ever experienced or are you currently experiencing any injury to your shoulders, arms, elbows, wrists or hands? If yes, please note injury and date below.	Y	N
Have you ever experienced or are you currently experiencing any injury to your neck or back? If yes, please note injury and date below.	Y	N
Have you ever experienced or are you currently experiencing any injury to your hips, knees, ankles, or feet? If yes, please note injury and date below.	Y	N
Have you ever had any surgical procedures? If yes, please note surgery and date below.	Y	N
Are you currently receiving any health care such as massage therapy, chiropractic, or physical therapy? If yes, please list below.	Y	N
Are you aware of any other medical conditions of note such as diabetes, heart disease, thyroid problems, or elevated cholesterol? If yes, please list below.	Y	N

List all current medications and food supplements.

Please identify any health problems that have occurred in your immediate family:

Please complete the Par-Q Physical Activity Readiness Questionnaire (attached)

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Goals

I. Goals should be SMART – Simple, Measurable, Attainable, Realistic, and Time-Based. Please list your current goals related to your physical therapy program:

Personal Goals:

Event And Performance Goals: please list the event(s) for which you are currently training (if any).

	Date	Event	Distance	Goal Time/Pace
1.				
2.				

II. Overall Daily Function

Please identify up to 2 important activities that you are unable to do or have difficulty with as a result of your problem, and rate the activity from “unable to perform activity” to “able to perform activity at pre-injury level”.

Activity 1:_____

0	1	2	3	4	5	6	7	8	9	10
Unable to perform activity										Able to perform activity at pre-injury level

Activity 2: _____

0	1	2	3	4	5	6	7	8	9	10
Unable to perform activity										Able to perform activity at pre-injury level

Over the past 24 hours, has the pain limited you from performing any of your normal daily activities?

0	1	2	3	4	5	6	7	8	9	10
Activities have not been limited										Activities have been severely limited

III. Pain Level:

Make a mark (|) across the line to indicate how bad your pain is between the extremes of “No pain at all” on the left of the line and “Pain as bad as it could be” on the right of the line.

No pain at all----------Pain as bad as it could be

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Expectations

For physical therapy clients:

Please list your expectations of a physical therapist below.

Please think about the kind of physical therapy clinic that would deliver excellent quality of service – the kind of physical therapy clinic at which you would be pleased to receive treatment. Please show the extent to which you think such a physical therapy clinic would possess the feature described by each statement. If you feel a feature is not at all essential for excellent physical therapy clinics such as the one you have in mind, circle the number 1. If you feel a feature is absolutely essential for excellent physical therapy clinics, circle 5. If your feelings are less strong, circle one of the numbers in the middle. There are no right or wrong answers – all we are interested in is a number that truly reflects your feelings regarding clinics that would deliver excellent quality of services.

	Strongly Disagree				Strongly Agree
Excellent therapists will provide me with education regarding my specific problem, self-care, and the nature of my treatments	1	2	3	4	5
Excellent therapists will give me individual attention and will change my treatment program to meet my specific goals and needs	1	2	3	4	5
Therapists in excellent physical therapy clinics have the knowledge and skills necessary to help their patients and answer their questions	1	2	3	4	5
Excellent physical therapy clinics will respond to phone calls and email inquiries in a timely fashion	1	2	3	4	5
Excellent therapists will use measurement to show me how I have improved	1	2	3	4	5
	Strongly Disagree				Strongly Agree

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Acknowledgement, Waiver, and Release From Liability – Physical Therapy

Acknowledgement: I certify that, to my knowledge, I do not have any limiting medical condition that would preclude or limit my participation in a training program and I accept full responsibility for my participation in the program. I certify that I have not been advised against participation by a qualified health professional. I have been informed of the value of a physician's approval for participation in this type of progressive training program. I fully understand that it is my responsibility to inform SSI of any injury, illness, infection, drug or condition that would prevent my full participation in the program. [initial _____]

Waiver and Release: I waive, release, and discharge from any and all claims, losses, or liabilities for death, personal injury, partial or permanent disability, property damage, medical or hospital bills, theft, or damage of any kind, including economic losses, which may in the future arise out of or relate to my participation in or my traveling to and from any activities at SSI and South Congress Athletic Club (SCAC). In consideration of the above, I, for myself, my heirs, and assigns, hereby release Allan Besselink, SSI, and SCAC from any claims, demands and causes of action arising from my participation in this training program and coaching.

I accept complete responsibility for my health and well-being in this voluntary training program and understand that no responsibility is assumed by Mr. Besselink, SSI, or SCAC. I waive any claim or cause of action for any personal damage or injury which I may sustain, whether occurring during or after my participation in the training program, and which may be blamed upon or allegedly be a result of such program. [initial _____]

Informed Consent: I understand that my participation in physical therapy treatment at Smart Sport International is voluntary. I agree to provide the treating therapist with necessary information and feedback prior, during, and after each treatment session for the purpose of maximizing treatment effectiveness and minimizing the risk for any adverse treatment effects. I consent to evaluation and treatment by this licensed physical therapist. I have participated in setting goals for my treatment plan which has been explained to me by the therapist. [initial _____]

Consent For Photography and Videotaping: I freely and voluntarily consent to participate in a videotape recording as it relates to my program. I understand that the purpose of this is to enhance and individualize the development of my program and to use as a research and educational database. I hereby authorize Allan Besselink to keep, preserve, use and dispose of this videotape for these purposes under the provision that my name will not be associated with any of the results unless given my express written consent to do so. [initial _____]

Payment Responsibility: I am the party responsible for payment of all services. I agree to make full payment within 30 days of notification of any remaining balance, or make suitable arrangements with SSI to do so. I have read the above policies and procedures and understand them as they relate to me. I will abide by all policies and procedures noted above. [initial _____]

Acknowledgement of Receipt of Notice Of Privacy Practices
I have been offered a copy of the Notice of Privacy Practices for SSI on the SSI website (www.smartsport.info).

Acceptance of Policies:
To the best of my knowledge, the above information is true and correct, and I fully understand the policies stated above.

_____ _____
Participant's Signature Date

_____ _____
Parent/Guardian Date