WELCOME TO ROCK INSTITUTE

A HIGH PERFORMANCE WELLNESS COMPANY

Intake Evaluation Form 2013

*First Name: _____ *Last Name: _____ *DOB: _____ Date: _____/_____/_____

*Home # _____
*Cell # _____
*Email _____
Work # _____
Fax # _____

*Address: _____
*City: _____ *State: _____ *Zip: _____

*Referred by: _____ Doctor: _____

*Referred to/for which Service: _____

***Billing Information:** (If different from above)
Address: _____ City: _____ State: _____ Zip: _____

*Emergency Contact (1): Name: _____ Phone #: _____
Emergency Contact (2): Name: _____ Phone #: _____

List physical problems or present injuries that concern you most. (In order of importance)

1._____ 3._____
2._____ 4._____

SURGERIES: (Please list if any foreign objects that have been placed in your body, if any?)

Operation/Procedure	Date	Purpose

Are you currently on any medications?

Medication	Purpose / Dosage	Medication	Purpose/Dosage

List any allergies to foods or medications:

Allergies:	Allergies to Foods:	Allergies to Medications:

List any physicians/healthcare providers you are seeing?

Physician or health Care providers:
_____
_____
_____
_____

Choose a number for each of the following:

_____ Water total ounce average per day (8oz = 1 cup)
_____ Wine or alcoholic drinks per day
_____ Caffeine (coffee, tea, etc) drinks per day
_____ Soft Drinks per day
_____ Smoking (cigarettes, cigars, etc) per day

Personal Health Profile: Do you have or experience any of the issues below?

_____ Asthma	_____ Fatigue	_____ Dizziness	_____ Metal Implants
_____ Thyroid Problems	_____ Nerve Problems	_____ Headaches	_____ Cancer
_____ High Cholesterol	_____ Liver Problems	_____ Numbness	_____ Seizure
_____ Diabetes	_____ Sciatica	_____ Hernia	_____ Pregnant
_____ Pacemaker	_____ Lung Problems	_____ Heart Problems	_____ Stroke
_____ High Blood Pressure	_____ Allergies	_____ Nausea	_____ Measles
_____ Chest Pain	_____ Chicken Pox	_____ Mumps	Other: _____

Injury Assessment:

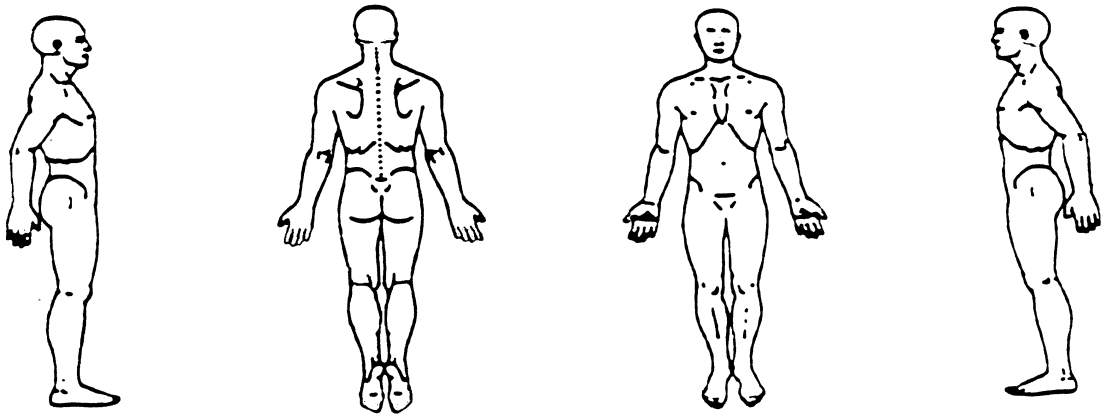
List or describe present problem(s) with pain or "nagging" issue(s): _____

_____

_____

_____

"X" picture below where you currently have pain, numbness, tingling or nagging symptoms:



Rate your pain at rest 1-10 (10 worst): 0 1 2 3 4 5 6 7 8 9 10

Rate your pain during activity: 0 1 2 3 4 5 6 7 8 9 10

Rate your limitation of overall function: 0 1 2 3 4 5 6 7 8 9 10

How did injury(s) occur: _____

_____

What Type of Pain: (Circle) Dull Sharp Tingling Shooting Burning Throbbing Ache Numbness Stabbing

How often are the complaints present: Constant (75-100%) Frequent (50-75%) Occasional (26-50%) Intermittent (5-25%)

What Specific movement causes pain: _____

What relieves the pain: _____

Explain any prior injury to the area: _____

_____

Who treated the injury: _____

What was the diagnosis: _____

Was an X-ray administered? If yes, date: _____. **Was an MRI administered? If yes, date:** _____.

What was the course of treatment: _____

Did treatment help: _____

Any other recommendations made: _____

Patient Signature: _____ **Date:** _____

Parent Signature (Under 18): _____ **Date:** _____

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POLICIES & LIABILITY RELEASE

It is strongly suggested that each client complete a medical evaluation with your Doctor before commencing any fitness performance program.

1) I take full responsibility for my health and affirm that I have no medical problems that would prevent me from participating in any RI fitness/Performance training, rehabilitative, Far Infrared Sauna and/or, nutrition program.
Initials: _____

2) I understand that each session must start at the scheduled appointment time and in the event that I am late to an appointment the session will finish at the scheduled time and I will be charged for the full session.
Initials: _____

3) If I miss an appointment or, wish to reschedule, I must provide a 24-hour advance notification. I understand that if I do not provide 24-hour notice I will be charged the full rate for that session.
Initials: _____

4) In the event that I am involved with any "group" program or clinic I understand that I am receiving discounted rates and agree to the following; 1) that the sessions must start and end on time, 2) the reduced fees will be charged whether I attend the full session or not and, 3) I cannot change the appointment times/days, without RI's written approval.
Initials: _____

5) I understand that all of RI's service fees are my responsibility and I agree to pay them in full before commencing any RI program.

Initials: _____

6) I have read and understand all the program rates and policies and agree to abide by them.
Initials: _____

7) I understand that RI does not accept insurance assignments nor do we bill your insurance company(s). Our general experience is that most regular health insurance plans do not offer coverage/reimbursement for RI fitness training, rehabilitative and/or nutrition programs.
Initials: _____

8) RI uses photography and video with clients and I approve and give RI permission to use my name, photos and requested endorsements for assessment, training, continuing education, teaching clinics and for promotional purposes at RI's discretion.
Initials: _____

9) I understand that the ROCK Institute may perform a Corrective Therapy Evaluation and that Corrective/physical Therapist are not allowed to make a medical diagnosis and that if the therapists deems it appropriate after performing the evaluation, I will be referred to a medical doctor for further evaluation.
Initials: _____

GENERAL RELEASE

I hereby certify that I have read and initialed all the above policies and agree to abide by them. To the best of my knowledge, I have no medical or physical limitations, which might prevent me from exercising or pursuing this specialized rehabilitative program at RI. I truthfully and accurately completed the Health Evaluation Sheet. I accept full responsibility for my own health and welfare. I understand there are inherent risks with any exercise or rehabilitation program. Knowing the risks involved, I have voluntarily applied to participate in the specialized rehabilitative program and agree to assume those risks and to release and hold harmless High Performance Wellness, Inc. - ROCK Institute, any RI representatives, staff, associates, employees or agents, as well as the owners and maintainers of any facility used for the activity, who, whether by negligence or carelessness, might otherwise be liable to me, or to my heirs or assigns, for damages. I acknowledge that if I am in a program/package or if a service is provided and a Credit Card is on file that my card will be charged for services rendered. I have read this general release, understand that I give up substantial rights by signing it, and I sign it voluntarily. This release shall be a continuing release and shall remain in effect until it is revoked in writing.

Print name: _____**Client Signature:** _____ Date: ____/____/_____

Print name: _____ **Parent/Guardian Signature**: _____ Date: ____/____/_____
(If under 18)