Minoru Pavilion Screening and Consent Form

Name:_____ Program:_____

Today's Date:_____ Birth Date: D_____ M_____ Y_____ ❑ Male ❑ Female

Home Address:_____ Postal Code:_____

Home Phone:_____ Work:_____ Other:_____

E-Mail Address:_____

Person to contact in case of emergency:_____ Phone:_____

Physician's Name:_____ Office Phone:_____

How did you find out about this program?_____

Does your physician know that you are taking this program? ❑ Yes ❑ No

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Health History – Please answer the following:

1. **Have you been diagnosed with osteoporosis?** ❑ No ❑ Yes
   If yes, number of years diagnosed and area affected:_____

2. **Have you had a low-trauma fracture?** ❑ No ❑ Yes If yes, when?_____
   Which bone was broken?_____

3. **Have you had surgery in the past 12 months?** ❑ No ❑ Yes
   If yes, please describe:_____

4. **Have you had a fall in the last 12 months?** ❑ No ❑ Yes If yes, was it indoors? ❑ No ❑ Yes

5. **Do you have a hernia, or any condition that may be aggravated by lifting weights?** ❑ No ❑ Yes
   If yes, please describe:_____

6. **Do you have any muscle or joint disorders (arthritis, fibromyalgia)?** ❑ No ❑ Yes
   If yes, please describe and area affected:_____

7. **How far/long can you walk without pain?**_____

8. **How long can you sit/stand without pain?** Sit:_____ Stand:_____

9. **How often do you experience back pain?** ❑ rarely ❑ frequently ❑ all the time

10. **Can you get down on the floor and get back up with minimal pain?** ❑ No ❑ Yes
    If no, please explain:_____

11. **Do you presently suffer from acute back pain?** ❑ No ❑ Yes
    If yes, are you receiving treatment?_____

12. **Have you had a surgical operation on your back?** ❑ No ❑ Yes
    If yes, please explain:_____

Richmond

13. **Do you experience any of the following?**
❑ radiating pain ❑ numbness and tingling ❑ swelling ❑ loss of function ❑ night pain

14. **Do you have a thyroid condition?** ❑ No ❑ Yes

15. **Do you have a history of breathing or lung problems (Asthma, COPD)** ❑ No ❑ Yes
If yes, please explain:_____

16. **Do you have Diabetes?** ❑ No ❑ Yes If yes, ❑ Type I ❑ Type II ❑ Border-line

17. **Do you have heart problems (chest pain, arrhythmias)?** ❑ No ❑ Yes
If yes, please explain:_____

18. **Do you have high blood pressure (hypertension)?** ❑ No ❑ Yes

19. **Are you a current smoker?** ❑ No ❑ Yes

20. **Are you physically active?** ❑ No ❑ Yes
If yes, please describe:_____

21. **Do you experience loss of balance or dizziness?** ❑ No ❑ Yes
If yes, please describe:_____

22. **Are you currently overweight/obese?** ❑ No ❑ Yes
If yes, please explain:_____

23. **Please list all medications you are taking.**

24. **Do you have any other medical conditions or concerns?**

Medical clearance is required prior to commencing with this physical activity program. We recommend seeing your doctor for this clearance, however you may alternatively begin with a call to PAL – The Physical Activity Line.

PAL is a free resource for practical and trusted physical activity and healthy living information provided by Certified Exercise Physiologists. The professionals at PAL can perform your initial screening, and advise you as to whether or not a visit to your physician is required.

PAL will provide you with a Physical Activity Clearance Documentation form, which must be provided to our office for registration purposes.

PAL: www.physicalactivtyline.com 604-241-2266

Participant Informed Consent Form

I understand that the Richmond Community Wellness program will provide me with a physical activity program, which will include activities designed to place a gradually increasing workload on the cardiovascular system. I understand that the reaction of the system to such activities cannot always be predicted with complete accuracy and therefore there is a risk associated with exercising. I also understand and accept that these risks may occur during or following an exercise session. I understand and accept the risks of participating in physical activity, including the risks resulting from my participating in the Richmond Community Wellness Physical Activity Program, and that I may suffer personal injury while participating in the program.

By signing this release, I assume all the risks of injury, loss, or expense of any kind resulting from my participation in the program. I will not hold the Richmond Fitness and Wellness Association, City of Richmond or the staff associated with the program, liable for any injury, loss, or expense suffered as a result of my participation. This release will apply to each and every session that I participate in the program.

I have read, understood, and fully agree to the foregoing. Any questions I had have been answered to my satisfaction.

Signed on the _____ day of (month) _____, 20_____

By:_____ _____

Participant's signature Print name

Consent of Referral: Physician or Cardiologist

(Please complete the following or attach a copy of patient discharge summary)

Date:_____

Risk Stratification for exercise: ❑ Low ❑ Moderate ❑ High

Recommended Target Heart Rate:_____ Rate of perceived exertion:_____ /10

Hypertension: ❑ No ❑ Yes Blood Pressure:_____ Date:_____

A1C:_____ Date:_____

Lipid profile: Total:_____ HDL:_____ LDL:_____ Triglycerides:_____

VLDL:_____ Cholesterol:_____

Exit Exercise Stress Test Date:_____ ❑ Modified Bruce ❑ Bruce Protocol Time:_____

Current BMI:_____

Please identify any recommendations or restrictions for your patient's fitness program below:

❑ This patient is medically stable and safe to continue in the community physical activity wellness program.

❑ I recommend avoidance of:_____

❑ Unrestricted physical activity, start slowly and build up gradually.

I consider my patient _____, to be a reasonable candidate for the Richmond Community Wellness Physical Activity Program. Further, I understand this is a community wellness program without medical supervision, which is suitable for my patient.

_____ _____

Physician's Signature Print Name

_____ _____

Cardiologist's Signature Print Name