INSPIRE
EXERCISE MEDICINE

Agreement, Acceptance and Assumption of Liability, Release of Liability and Permission to Photograph and Record Video

Patient Name: _____ **Date:**_____
(Print)

In consideration of being allowed to participate in the activities and programs of Inspire Exercise Medicine and to use its facilities, equipment, and machinery, I acknowledge, confirm and agree as follows:

I understand and am aware that strength, fitness, flexibility, and aerobic exercise, including the use of equipment, is a potentially dangerous activity. I understand that such activities involve a risk of injury, even death, and that I am voluntarily participating in such activities and using equipment and machinery with knowledge of the dangers involved. I expressly assume and accept any and all risks of injury or death from the use of such equipment.

I do hereby acknowledge that I have been informed of the need for my physician's approval for my participation in an exercise/fitness activity or in the use of exercise equipment and machinery. I also acknowledge that it has been recommended that I have a yearly or more frequent physical examination and consultation with my physician as to physical activity, exercise, and use of exercise and training equipment so that I might have recommendations concerning these fitness activities and equipment use. I acknowledge that I have either had a physical examination and have been given my physician's permission to participate, or that I have decided to participate in activity and/or use of equipment and machinery without the approval of my physician and do hereby assume the risk of and all responsibility for my participation in such activities, and any utilization of equipment and machinery in such activities.

I understand that Inspire Exercise Medicine and its dietician, Greer Burcky, MS, RDN/LDN, CPT, who is a Registered and Licensed Dietitian/Nutritionist, and/or any other Dietitian/Nutritionist, do not dispense or provide medical advice nor prescribe treatment. Rather, they provide education to enhance my knowledge of health as it relates to foods, dietary supplements, and behaviors associated with eating. While nutritional and botanical support can be an important complement to my medical care, I understand nutrition counseling is not a substitute for diagnosis, treatment, or care of disease by a medical provider.

I acknowledge that I take full responsibility for my life and well-being, as well as the lives and well-being of the my family and children (where applicable) who may attend diet, nutrition and education sessions with me, and for all decisions made by me during and after the duration of the my nutrition and wellness education sessions. I expressly assume and accept the risks of nutrition and wellness education sessions, including the risks of trying new foods, and the risks inherent in making lifestyle changes.

I hereby waive, release and forever discharge Inspire Exercise Medicine and its officers, agents, employees, representatives, and all others affiliated with it from any and all responsibility or liability for injuries or damages resulting from my participation in any activities and programs, including but not limited to, my use of equipment or machinery at Inspire Exercise Medicine or arising out of my participation in any other programs or activities in which I am engaged, including nutrition, diet and education, including those caused by the negligent act or omission of any of those mentioned or others acting on their behalf.

I understand that photographs and digital videotapes of me or others may be recorded at the Inspire Exercise Medicine clinic at any time. Also, those photos and videos may be used to document my care and progress, but may be used for promotional purposes by Inspire Exercise Medicine with additional written consent before sharing outside of the clinic. I consent to this recording of images and videos, and to the later use of these images and

videos on the Inspire Exercise Medicine. I understand that Inspire Exercise Medicine retains ownership rights to these digital images/videos, but I will be able to request a copy at any time.

Images that identify me can only be released and/or used outside of Inspire Exercise Medicine upon additional prior written authorization from me and only if they are released for purposes other than treatment, payment, or healthcare operations.

I understand that I am not permitted to take pictures or make video or audio recordings of any Inspire Exercise Medicine locations or clinicians, as well as of any employees or clients.

_____ _____

Patient Signature Date

_____ _____

IEM Staff Signature Date

INSPIRE
EXERCISE MEDICINE

HEALTH HISTORY QUESTIONNAIRE

First Name_____Last Name_____Date:_____

Emergency Contact Name_____Emergency Contact Phone_____

Please List The Primary Physician_____Phone _____

Please List The Physician Who Referred You_____ Phone _____

Have you ever had any of the following?

Heart Attack	☐ YES	☐ NO	Emboli (blood clot)	☐ YES	☐ NO
Angina	☐ YES	☐ NO	Coronary Artery Disease	☐ YES	☐ NO
Asthma	☐ YES	☐ NO	Stroke	☐ YES	☐ NO
Anemia	☐ YES	☐ NO	Cancer	☐ YES	☐ NO
Osteoporosis	☐ YES	☐ NO	Pulmonary Disease	☐ YES	☐ NO
Heart Surgery	☐ YES	☐ NO	Heart Valve Problems	☐ YES	☐ NO
Rheumatic Fever	☐ YES	☐ NO	Phlebitis (vein inflammation)	☐ YES	☐ NO
Emphysema	☐ YES	☐ NO	Currently Pregnant	☐ YES	☐ NO

Please list all known allergies:_____

Please list the type of cancer you were treated for:_____

Are you on chemotherapy currently? Yes/No (circle)
In the past? Yes/No (circle)

DO YOU HAVE A PACEMAKER/DEFIRBILLATOR: Yes/No (If so, let facility personnel know immediately)

If you are a male over the age of 45 or a woman over the age of 55 OR if you answered "YES" to two (2) or more of the above Major Risk Factors, it is STRONGLY RECOMMENDED that you receive physician's clearance before beginning your exercise program.

Do you have any of the following?

Pain/discomfort (or angina equivalent) in the chest/neck/jaw/arms/other areas	☐ YES	☐ NO
Shortness of breath at rest or with mild exertion	☐ YES	☐ NO
Dizziness or fainting with rest or mild exertion	☐ YES	☐ NO
Labored breathing at rest or with mild exertion	☐ YES	☐ NO
Edema (excessive accumulation of tissue fluid)	☐ YES	☐ NO
Palpitations or tachycardia (sudden rapid heartbeat)	☐ YES	☐ NO
Intermittent claudication (lameness due to decreased blood flow)	☐ YES	☐ NO
Known heart murmur (abnormal heart sound)	☐ YES	☐ NO
Unusual fatigue or shortness of breath with usual activities	☐ YES	☐ NO

Cardiovascular: cardiac, peripheral vascular, cerebro-vascular disease	☐ YES	☐ NO
Pulmonary: chronic obstructive pulmonary disease, asthma, interstitial lung disease, cystic fibrosis	☐ YES	☐ NO
Metabolic Disease: Diabetes Mellitus (Type I & II), thyroid disorders, renal or liver disease	☐ YES	☐ NO

If you answered "YES" to any of the Signs & Symptoms listed above OR have known cardiovascular, pulmonary, or metabolic disease (as defined above), it is STRONGLY RECOMMENDED that you receive physician's clearance before beginning your exercise program.

I understand this Health History Questionnaire has been provided to me for the purpose of helping mebetter understand any potential risks associated with an exercise program. I also understand that Ishould share this information with my physician and seek his or her approval prior to beginning anexercise program. I understand the information I have provided will be maintained in my membership file for use in case of a medical emergency. My signature signifies that all the above is true, to the bestof my knowledge. Any information left unanswered was done so intentionally. If any of the aboveinformation changes, I agree to submit these changes in writing to this facility's wellness professionalfor an update to my membership file.

Signature:_____ Date:_____

I understand this Health History Questionnaire has been provided to me for the purpose of helping me better understand any potential risks associated with a workout program, to share with my physician in order to obtain his or her approval before beginning an exercise program, and to be maintained as part of my file in case of a medical emergency.

Signature:_____ Date:_____

Godin Leisure-Time Exercise Questionnaire

During a typical **7-Day period** (a week), how many times on the average do you do the following kinds of exercise for **more than 15 minutes** during your free time (write on each line the appropriate number).

Weekly leisure activity score = (9 × Strenuous) + (5 × Moderate) + (3 × Light)

	Times per week		Totals
a) **STRENUOUS EXERCISE (HEART BEATS RAPIDLY)** (e.g., running, jogging, hockey, football, soccer, squash, basketball, cross country skiing, judo, roller skating, vigorous swimming, vigorous long distance bicycling)		**X9**	
b) **MODERATE EXERCISE (NOT EXHAUSTING)** (e.g., fast walking, baseball, tennis, easy bicycling, volleyball, badminton, easy swimming, alpine skiing, popular and folk dancing)		**X5**	
c) **MILD/LIGHT EXERCISE (MINIMAL EFFORT)** (e.g., yoga, archery, fishing from river bank, bowling, horseshoes, golf, snow-mobiling, easy walking)		**X3**	
WEEKLY LEISURE-TIME ACTIVITY SCORE			

EXAMPLE

Strenuous = **3** times/wk Moderate = **6** times/wk Light = **14** times/wk

Total leisure activity score = (9 × **3**) + (5 × **6**) + (3 × **14**) = 27 + 30 + 42 = 99

Godin Scale Score	Interpretation
24 units or more	Active
14 – 23 units	Moderately Active
Less than 14 units	Insufficiently Active/Sedentary

Adapted from: Godin, G. (2011). The Godin-Shephard leisure-time physical activity questionnaire. Health & Fitness Journal of Canada, 4(1), 18-22.

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Under each heading, please check the ONE box that best describes your health TODAY.

MOBILITY

- I have no problems walking ☐
- I have slight problems walking ☐
- I have moderate problems walking ☐
- I have severe problems walking ☐
- I am unable to walk ☐

SELF-CARE

- I have no problems washing or dressing myself ☐
- I have slight problems washing or dressing myself ☐
- I have moderate problems washing or dressing myself ☐
- I have severe problems washing or dressing myself ☐
- I am unable to wash or dress myself ☐

USUAL ACTIVITIES *(e.g. work, study, housework, family or leisure activities)*

- I have no problems doing my usual activities ☐
- I have slight problems doing my usual activities ☐
- I have moderate problems doing my usual activities ☐
- I have severe problems doing my usual activities ☐
- I am unable to do my usual activities ☐

PAIN / DISCOMFORT

- I have no pain or discomfort ☐
- I have slight pain or discomfort ☐
- I have moderate pain or discomfort ☐
- I have severe pain or discomfort ☐
- I have extreme pain or discomfort ☐

ANXIETY / DEPRESSION

- I am not anxious or depressed ☐
- I am slightly anxious or depressed ☐
- I am moderately anxious or depressed ☐
- I am severely anxious or depressed ☐
- I am extremely anxious or depressed ☐

- We would like to know how good or bad your health is TODAY.
- This scale is numbered from 0 to 100.
- 100 means the best health you can imagine.
  0 means the worst health you can imagine.
- Mark an X on the scale to indicate how your health is TODAY.
- Now, please write the number you marked on the scale in the box below.

YOUR HEALTH TODAY = ☐