True Health Center

FORM 1 - PATIENT DEMOGRAPHICS

Last Name:		First:	MI:
DOB:	Gender:	Status: (Single) (Partner) (Married)	Date:
Mailing Address:			Chart#
City:	State:	Zip+4	
Home#	Cell#	Email:	
Would you prefer? Text Reminders: (Yes) (No) ///// Email Reminders (Yes) (No)			
Emergency Contact:		Relationship:	
Emergency Contact Home #		Cell#	
Purpose for Testing: ( ) Athlete ( ) Health Assessment ( ) Medical Concerns ( ) Fitness Assess.			
Referred : ( ) Health / Risk Factors ( ) Doctor Referred ( ) Recent Health Scare ( ) Improve Health ( ) Poor Health			

Cardiovascular Health Issues - Check Applicable Boxes

- ☐ Heart Attack / Myocardial Infarction
- ☐ Chest Pain or Pressure
- ☐ Arrhythmia / Palpitations
- ☐ Congestive Heart Failure
- ☐ Tachycardia - Fast Heart Rate
- ☐ Bradycardia - Slow Heart Rate
- ☐ Heart Surgery /Stents / By-Pass/ Valves
- ☐ High Cholesterol
- ☐ Heart Murmur
- ☐ Swollen Ankles
- ☐ Heart Value Problems
- ☐ Stroke
- ☐ Shortness of Breath
- ☐ Chest Tightness
- ☐ Obesity

Pulmonary - Other Health Issues - Check Appropriate Boxes

- ☐ COPD - Athsma
- ☐ COPD - Chronic Bronchitis
- ☐ COPD - Emphysema
- ☐ Shortness of Breath
- ☐ Sleep Apnea
- ☐ Smoker / Past Smoker
- ☐ Arthritis - OA or RA
- ☐ Allergies / Sinuses
- ☐ Dizziness / Vertigo
- ☐ Thyroid - Hypo... / Hyper...
- ☐ Musculoskeletal Pain
- ☐ High Stress
- ☐ Diabetic / Pre-diabetic
- ☐ Neuropathy
- ☐ Unexplained Leg Pain / Fatigue
- ☐ Chronic Fatigue
- ☐ Kidney Disease
- ☐ Liver Disease

Health Survey Questions

LEVEL OF PHYSICAL ACTIVITY

- ☐ Sedentary - Desk/Seated Job - No Regular Exercise
- ☐ Lite Activity - Walk 2-3x week - Total time 90+ mins
- ☐ Moderate Activity - Aerobic Exercise 3x wk 150+ mins
- ☐ High Activity - Aerobic / Anaerobic - 300+ mins week
- ☐ Athlete - Regular Intense Vigorous Training

YOUR LIMITATIONS

- ☐ Joint Issues - Example - Knee, ankle, low back pain
- ☐ Anxiety
- ☐ Shortness of Breath
- ☐ Leg pain or Fatigue

FAMILY HISTORY

- ☐ Heart Disease
- ☐ Heart Attack
- ☐ High Blood Pressure
- ☐ Obesity
- ☐ Stroke
- ☐ Diabetes
- ☐ Allergies
- ☐ Arthritis
- ☐ COPD

INTERESTED IN?

- ☐ True Health Program
- ☐ V02 Cardiopulmonary Testing
- ☐ 3D Body Composition Scan
- ☐ Resting Metabolic Rate Test
- ☐ True Weight Loss Program
- ☐ Physical Exam
- ☐ Set Physical Exercise Plan
- ☐ Review my health status, set a plan to improve my health

Printed Name: _____

Signature of Patient: _____

Printed Name Witness_____

Signature of Witness: _____

True Health Center

Participant Activity Readiness Questionnaire

Last Name:	First Name	Date:		
Date of Birth:	Age	Gender (M) (F)		
Has a doctor ever said you have a heart condition?			Y	N
Has a doctor ever limited your physical activity? Gave you recommendations to limit activity?			Y	N
Do you feel pain in your chest when you do physical activity?			Y	N
In the past month, have you had chest pain when you are not doing physical activity?			Y	N
Do you or have you lost your balance because of dizziness, or loss consciousness?			Y	N
Is your doctor currently prescribing drugs for blood pressure or heart conditions?			Y	N
Do you have a bone, joint, or muscular issue that could be made worse by a change in physical activity?			Y	N
Do you have COPD, Asthma, Chronic Bronchitis, or any other Respiratory issue?			Y	N
If on medications, do any affect your heart rate?			Y	N
Do you ever have or had ankle / Feet swelling?			Y	N
Are you on Beta Blockers for your heart / blood pressure			Y	N
Have you been or are you now anemic?			Y	N

Medications - Please List Medications or Provide Us with a List to Copy

Medication Name	Dosage	Purpose of Medication

☐ If you have any questions about your heart, or medications affecting your heart, please consult your doctor before proceeding with any physical testing.

☐ I have reviewed these questions and answered them to the best of my ability. I understand that these materials will be reviewed and I may be asked to see my doctor before participating.

☐ I also give permission for my testing information to be used in studies, publications, and community awareness materials on the importance of Fitness and Health, understanding that my personal information will be removed and not published in any format unless I give specific permission in writing.

_____ _____

Signature Date

True Health Center
Form 3 - Informed Global Consent
V02 CONSENT

☐ I hereby consent to engage voluntarily to V02 Testing, which demands moderate to vigorous exercise on a treadmill or stationary bike for 10 to 20 minutes

☐ I choose True Health Center (Westside Family Acupuncture) to do Physiological Testing in order to determine my Cardiorespiratory health and fitness, and provide recommendations for improving my health status and or weight loss

☐ In the event that a medical clearance must be obtained prior to my participation in the exercise program, I agree to consult my physician or one of the physicians at Westside Family Acupuncture, to obtain written permission prior to V02 testing and/or admittance into the True You Weight Loss Program.

☐ Before I undergo the V02 test and/or Weight Loss Program, I certify that I am in good health and have had a physical examination within the last _____ months. If I have not had a physical exam, one may be required.

☐ I hereby represent that I have completed the Health History form and have provided correct responses to the questions on this form. I recognize that my failure to do so could lead to possible unnecessary injury to myself.

☐ I have been informed and understand I will undergo a physical performance test, which uses a treadmill or bike, along with a Medical Gas Analyzer Cart which measures CP function, oxygen utilization, and the musculoskeletal system.

☐ I understand that during this test intensity will gradually be increased until symptoms such as fatigue, shortness of breath, chest discomfort may appear, indicating to me that I should stop. I understand I can, and must stop the test if any point if there is a concern. The Technician will help stop the equipment, and get you to a comfortable position, assess the situation with you, and make a decision if medical intervention is needed (911)

☐ I understand that I am responsible for monitoring my own condition throughout the exercise test or fitness program and should any unusual symptoms occur, I will cease my participation and inform the Health Center staff of my symptoms.

☐ I understand that the reaction of my heart, lungs, and blood vessels to such exercise cannot always be predicted with accuracy. I know there is a risk of certain abnormal changes occurring during or following exercise which may included abnormalities of blood pressure or heart rate, ineffective function of the heart and in rare instance, heart attack or death. Physical testing can lead to musculoskeletal strains, pain and injury if adequate safety procedures are not followed.

☐ I understand a Physiology Technician will be with me the entire time, and will be administering the test.

☐ In signing this consent form, I affirm that I have read this form in its entirety and that I understand the nature of the exercise program. I also affirm that my questions regarding the V02 Test have been answered to my satisfaction. Also, in consideration for being allowed to participate in the Fitness Center program, I agree to assume the risk of such exercise, and further agree to hold harmless True Health Center (Westside Family Acupuncture), its staff members and affiliates who supervise the exercise program from any and all claims, suits, losses or related causes of action for damages, including, but not limited to, such claims that may result from my injury or death, accidental or otherwise, during or arising in any way from the V02 exercise testing at the True Health Center.

☐ I will be referred to see one of the doctors (WSFA) who specialize in the results and interpretation of your V02 test.

☐ In an emergency, please notify: _____ # _____

_____ _____

(Print Name and Signature of Participant) (Date)

☐ Patient / Client is required to see their PCP or WSFA Physician for written permission for V02 Testing

☐ A Physical Exam and Evaluation is Required prior to testing

True Health Center

STYKU BODY SCAN INSTRUCTION AND RISKS

I hereby agree to receive a Styku 3D Body Scan which involves the following:

_____ I understand I need to come dressed or change into tight skin forming cloths or limited clothing such as tight shorts and sports attire. I understand the scan is actually measuring my entire body and tight fitting cloths are required for accurate measurements

_____ I understand that long hair needs to be tied up high on the head so the scanner can measure the neck and shoulders accurately.

_____ I understand I will be stepping onto a platform that rotates 360 degrees slowly and must be still during the 30+ seconds of the scan

_____ I do not have a physical condition that would put me at risk during the scan, such as dizziness, vertigo, inability to stand still for 45 seconds, severe pain, or any other condition.

_____ I understand I am providing personal information and email information for the purpose of the scan and to receive the report of the scan (PDF) to my email. (All Medical Information in our office follows HIPA Requirements of Privacy)

_____ I understand I will receive an overview and basic interpretational results of my 3d Body Composition Scan with our Physiology Tech.

_____ I understand that <u>if</u> the results of my test show I have moderate to high health risks, then it is recommended to schedule an appointment with one of our doctors to review those risks and provide recommendations for improving my health.

RESTING METABOLIC RATE RISKS

_____ I hereby consent to engage <u>voluntarily</u> to RMR Testing, which requires being stationary in a chair or bed for 10 to 20 minutes

_____ I understand the test requires wearing a mouthpiece that is connected to a Gas Analyzer, which measures my Oxygen utilization, Carbon Dioxide production, and respiratory volume for the purpose of calculating one's individual resting metabolism for a 24 hour period.

_____ I do not have a physical condition that would put me at risk during the test.

_____ I understand I am providing personal information and email information for the purpose of the RMR Testing. (All Medical Information in our office follows HIPA Requirements of Privacy)

_____ I understand I will receive an overview and basic interpretational results of my RMR with one of our providers.

_____ I understand that **<u>if</u>** the results of my test show I have moderate to high health risks, then it is recommended to schedule an appointment with one of our doctors to review those risks and provide recommendations for improving my health.

Informed Consent to Testings and Risks

I agree to assume the risk of such testing, and further agree to hold harmless True Health Center (Westside Family Acupuncture), its staff members and affiliates who supervise perform our health program from any and all claims, suits, losses or related causes of action for damages, including, but not limited to, such claims that may result from my injury or death, accidental or otherwise, during or arising in any way from Styku 3D Body Scan Testing, V02 exercise testing, RMR Testing, Field Testing, or any other Physiology Testing or Training recommended or required by our program, at the True Health Center / Westside Family Acupuncture.

Office Staff Signature: _____ DATE: _____

_____ _____

Patient Printed Name Patient Signature