

JUST BE FIT, INC.

EXERCISE BASED REHABILITATION

Client: _____

Fitness Specialist: _____

Information:

- ____ Policies and Procedures regarding Gym facilities
- ____ Schedule Sessions
- ____ Business Cards/ Phone Numbers
- ____ Phone Numbers
- ____ Cancellation Policy
- ____ Fee Collection

Paperwork:

- ____ Health History Questionnaire
- ____ Billing Contract
- ____ Informed Consent- Just Be Fit
- ____ Medical Release
- ____ Doctors Script
- ____ Rehab Assessment

Evaluation:

- ____ RHR/THR Range
- ____ Blood Pressure
- ____ Weight
- ____ ROM
- ____ Strength Tests
- ____ Gait Tests
- ____ Suggested re-evaluation date
- ____ Goal Setting*

Nutrition:

- ____ Food diary
- ____ Eating Tips
- ____ Schedule Consultation Date- _____

E-mail Preferences:

General

Specific:

- ____ Arthritis
- ____ Breast Cancer
- ____ Cardiac Rehab
- ____ Diabetes
- ____ Fibromyalgia
- ____ Osteoporosis
- ____ Parkinson's
- ____ Stroke

Body:

- ____ Back
- ____ Foot
- ____ Leg
- ____ Neck
- ____ Shoulder

Sport:

- ____ Basketball
- ____ Bowling
- ____ Cycling
- ____ Football
- ____ Golf
- ____ Racquet
- ____ Running
- ____ Skiing
- ____ Soccer
- ____ Swimming
- ____ Volleyball

Insurance Information:

ICD-9 codes: _____

Diagnosis: _____

Target Heart Rate (THR) Determination

Age Predicted

1. Estimate Maximum Heart Rate (Max HR)

220

- ____ (age)
(Max HR)

2. Multiply the desired intensity range (60-90%)

(Max HR) (Max HR)
x .60 (Intensity) x .90 (Intensity)
(Target HR) (Target HR)

Target Heart Rate Range _____ bpm

REHABILITATION

HEALTH HISTORY / LIFESTYLE QUESTIONNAIRE

NAME: _____ DATE: _____
ADDRESS: _____ CITY: _____
PHONE (HOME): () _____ CELL: () _____
PHONE (BUSINESS): () _____ FAX: () _____
E-MAIL ADDRESS: _____ OCCUPATION: _____
AGE: _____ BIRTH DATE: ____/____/____ HEIGHT: _____ WEIGHT _____
MARRIED _____ SINGLE _____
Referred By: _____

Do you have children? () YES () NO / If so, how many? _____ Ages _____

In Case of Emergency, Contact: _____ Relationship: _____
Home Phone: () _____ Phone (Cell): () _____
Work () _____

Do you currently have a physician? () YES () NO

I) Physician's Name: _____ Phone: () _____
Address: _____
II) Physician's Name: _____ Phone: () _____
Address: _____

MEDICAL HISTORY

Have you ever had, or do you currently have, any of the following:

- | | |
|---|---|
| () Alcohol Abuse Problems | () Allergies |
| () Anemia | () Arthritis (Osteo/Rheumatoid/AS) |
| () Aneurism | () Anginia |
| () Asthma | () Back/Spinal Injury |
| () Bronchitis | () Cancer |
| () Chronic Obstructive Pulmonary Disease | () Cerebral Vascular Accident/Stroke |
| () Cerebral Palsy | () Coronary Vascular Disease |
| () Coronary Artery Disease/Heart Disease | () Circulatory Problems |
| () Diabetes Type I, Type II | () Embolism |
| () Emphysema | () Epilepsy |
| () Fibromyalgia | () Gastrointestinal/Stomach Problems |
| () Gout | () Head Injury |
| () Hearing Loss | () Heart Attack |
| () Hemorrhoids | () Hernia |
| () High Blood Pressure / Hypertension | () High Cholesterol |
| () High Triglycerides | () Hyperglycemia |
| () Hypoglycemia | () Crohn's Disease |
| () Kidney Disease | () Joint Problems (Knee/Shoulder/Hip/Back) |
| () Lung Disease | () Low Blood Pressure |
| () Muscular Dystrophy | () Multiple Sclerosis |
| () Osteoporosis | () Nervous/Emotional Tension |
| () Paralysis | () Parkinson's Disease |
| () Spina Bifida | () Poliomyelitis |
| () TMJ | () Spinal Cord Injury |
| () Tumors | () Thyroid Problems |
| () Varicose Veins | () Other _____ |

MEDICAL HISTORY, continued

Please comment here on any marked answers from above:

Have you recently experienced:

- Back/leg Pain _____
- Blurred or double vision _____
- Bowel/Bladder changes _____
- Brain Fog _____
- Calf pain with exercise _____
- Change in speech pattern _____
- Chest pain or pressure _____
- Constant pain unrelieved by rest or movement _____
- Difficulty keeping balance _____
- Difficulty sleeping _____
- Difficulty swallowing _____
- Dizziness, fainting, or blackouts _____
- Falls _____
- Fatigue _____
- Irregular heart beat _____
- Headaches/migraines _____
- Muscular pain at rest _____
- Muscular pain with exertion _____
- Numbness or tingling in arms, hands or legs _____
- Recurrent cough _____
- Ringing in ears _____
- Shortness of breath _____
- Swollen ankles or legs _____
- Swollen, stiff, or painful joints _____
- Tremors _____
- Unexplained weight gain _____
- Unexplained weight loss _____
- Unusual skin coloration _____
- Unusual weakness or fatigue _____
- A wound that does not heal _____
- Other _____

INJURIES

Have you ever had, or do you have, injuries to any of the following:

- ankle, foot arm, elbow back clavicle Hip
- face knee, thigh shoulder wrist/hand

Please comment here on any marked answer from above:

WOMEN'S HEALTH

1. Are you pregnant? () YES () NO
 2. When was your last menstrual cycle? _____
 3. Are you currently () premenopausal () postmenopausal () menopausal
 4. List any symptoms that accompany your menstrual cycle: _____
-

TREATMENT/SURGERIES

1. Have you undergone a complete medical exam within the last year? () YES () NO

2. Please list all medications you are taking:

Name	Reason	Amount	Frequency	Side Effects
------	--------	--------	-----------	--------------

3. Please list any homeopathic, herbal, vitamin, and/or mineral products that you are currently taking for the treatment of any condition or deficiency:

Name	Reason	Amount	Frequency	Side Effects
------	--------	--------	-----------	--------------

4. Please describe any surgery and/or hospitalizations:

Procedure	Reasons	Date
-----------	---------	------

5. Please list all current diagnostic test (location & date):

X-Rays: _____

MRI: _____

CAT Scan: _____

ECG: _____

Stress Test: _____

6. Identify any assistive devices you are currently using (cane, brace, etc.), whether the device was prescribed by a physician, and the reason for the device:
-
-

7. Please identify any past or ongoing treatments by a physician, physical therapist, chiropractor, massage therapist, acupuncturist, etc:

8. Has your physician ever advised you against exercise? () YES () NO

If YES, why? _____

LIFESTYLE / EXERCISE

PHYSICAL ACTIVITY

1. Are you currently involved in a regular exercise program? () Yes () No

If so, specify the frequency of exercise:

() Regularly (3-4 times/week) () Semi-regularly (1-2 times/week)

() Sporadic (1-2 times/month)

And the type of exercise:

() Cardiovascular (walk, jog, swim, bike, etc.) () Strength Training

() Martial Arts () Yoga () Pilates () Other _____

Describe Program: _____

2. If you answered "yes" to #1, how long have you been involved in the exercise program?

3. If you answered "yes" to #1, rate your perception of the exertion of your exercise program. () Light () Fairly light () Somewhat hard () Hard

4. If you answered "yes" to #1, what is the duration of each exercise session?

5. If you answered "no" to #1, have you been involved in a regular exercise program in the past:

_____ 6 months _____ year _____ other

If so, specify frequency, duration, type, and intensity:

6. What other exercise, sport, or recreational activities have you participated in:
the past 6 months?

the past 5 years?

beyond? _____

7. Were you a high school and/or college athlete? () Yes () No

If so, please specify the sport(s):

8. What types of physical activity do you consider enjoyable? _____

9. What are your personal barriers to exercise (i.e., your reasons for not exercising)?

() Lack of time () Lack of motivation () Frustration with lack of results

() Lack of knowledge about exercise techniques

() Other _____

10. What physical activity have you been successful with in the past (like and participated in regularly)? _____

11. Do you feel that your weight affects your daily activities? () Yes () No

If so how?

12. How do you rate your current level of fitness?

() Very Fit () Fit/Healthy () Average () Below Fit () Unhealthy

LIFESTYLE / EXERCISE,continued

SUPPORT

13. Do you feel any family, friends, or co-workers have or would have negative feelings (i.e., disapproval, resentment) toward your efforts at physical activity? () Yes () No ()
If so, explain_____

14. Is your significant other or a close friend involved in any regular physical activity?
() Yes () No
If so, who? What?_____

OCCUPATION / LEISURE

15. Does your present occupation require much activity (i.e., walking, getting up and Down, carrying things)? () Yes () No
If so, explain_____

16. Do you sit more than you are on the move at work? () Yes () No

17. What are your leisure activities?_____

STRESSORS

18. Do you consider your lifestyle as:
() Highly stressful () Moderately stressful () Low Stress

19. What types of things make you feel stressed?_____

20. How do you deal with your stress normally?_____

HABITS / MISCELLANEOUS

21. Have you ever smoked? () Yes () No () Quit
If so, for how long? _____ Do you smoke now? _____
Number of cigarettes/day: _____ Approximate date stopped: _____

22. Do you consume alcohol? () Yes () No
Drinks/day _____ What _____

23. Do you consume caffeine? () Yes () No # Sodas/day _____ # Coffee-Tea/day _____

SLEEP

24. How many hours of sleep do you get each night? _____

25. Is your sleep () continuous () interrupted _____
If it is interrupted, explain _____

26. What time do you: go to bed? _____ get up? _____

27. Is your sleep schedule consistent throughout the week or does it change frequently?

HEALTH & FITNESS GOALS / FLEXIBILITY

1. Please identify your reasons for participating in a lifestyle modification program:

- Physician recommendation Rehabilitation of injury

- Improve: Cardiovascular fitness Flexibility Energy Level
 Body (muscle/fat) composition Strength
 Performance for a specific sport Level of fitness

- Reduce: Cardiovascular risk factors Body fat / weight
 Amount of alcohol / cigarette consumption
 Risk of injuries
 Stress

2. What is your desired weight? _____
3. Where/when did you weigh yourself last? _____
4. What is the most you have ever weighed? _____ Date: _____
5. What is the least you have ever weighed? _____ Date: _____
6. Has your weight fluctuated **5** (five) pounds or more over the past **5** (five) years?
 YES NO
7. Do you consider yourself overweight? YES NO
8. Times of day that you will make available for exercise _____
9. Facilities available to you (home, fitness center, work, etc.):

10. Describe what you would like to accomplish through your lifestyle modification program? _____

11. Identify any time restrictions associated with the goals/expectations listed above?

(For Office Use Only)

Comments: _____

CARDIOVASCULAR HISTORY

1. Has your physician ever said you have heart or cardiovascular disease?
() YES () NO
2. Have you ever had Rheumatic Fever? () YES () NO
3. Have you ever had any diagnosed heart problems (murmur, valve defect)?
() YES () NO
4. Have you ever experienced abnormal chest pain? () YES () NO
5. Do you have unusual shortness of breath, history of dizziness, or fainting?
() YES () NO
6. Have you ever been diagnosed as having high blood pressure? () YES () NO
If yes, what value? _____/_____
7. Have you recently had your blood lipids / cholesterol screened? () YES () NO
If yes, what were the values? _____
8. Are you medicated for any of the situations listed above? () YES () NO

FAMILY MEDICAL HISTORY

Have your parents, grandparents, or siblings had any of the following (indicate who):

<input type="checkbox"/> Anemia	<input type="checkbox"/> Asthma	<input type="checkbox"/> Arthritis
<input type="checkbox"/> Back/Leg Pain	<input type="checkbox"/> Cardio/heart disease	<input type="checkbox"/> Congenital Heart disease
<input type="checkbox"/> Cancer	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Epilepsy
<input type="checkbox"/> Fatigue/lack of energy	<input type="checkbox"/> Feet/ankle swelling	<input type="checkbox"/> Heart operations
<input type="checkbox"/> High cholesterol	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Heart attack 50 or under
<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Lung disease	<input type="checkbox"/> Heart attack over age 50
<input type="checkbox"/> Migraines	<input type="checkbox"/> Phlebitis	<input type="checkbox"/> Recurrent cough
<input type="checkbox"/> Stroke	<input type="checkbox"/> Trouble sleeping	<input type="checkbox"/> Thyroid problems
<input type="checkbox"/> Stomach/gastrointestinal problems	<input type="checkbox"/> Other	

Comments:

I, the undersigned, state that I have answered this questionnaire to the best of my knowledge.

Signature

Date

THANK YOU FOR TAKING YOUR TIME TO PROVIDE THIS NEEDED INFORMATION.

(For Office Use Only)

Is a medical clearance form needed? () YES () NO

JUST BE FIT, INC.

EXERCISE BASED REHABILITATION

INFORMED CONSENT/RELEASE FOR PARTICIPATION IN A EXERCISE BASED REHABILITATION PROGRAM

I, _____, hereby consent to voluntarily engage in a exercise based rehabilitation program. I acknowledge it has been recommended to me by my fitness specialist that a physician of my choice examine me and obtain his/her approval for my participation in a program within 30 days of the date set forth below. Furthermore, within the 12 month period proceeding the date of this release, I have not been advised by a physician or other health care professional of any medical condition which would prevent me from participating safely in a physical fitness conditioning program.

If I am taking prescribed medications, I have informed my fitness specialist and further agree to so inform my trainer promptly of any changes, which my doctor or I have made with regard to use of any medications, or change in medical status. I will be given the opportunity for periodic assessments and evaluations at regular intervals after the start of my program. I have been informed that during my participation of the training session, I will be asked to complete the physical activities unless symptoms such as fatigue, shortness of breath, chest discomfort or pain occur. At that point, I have been advised that it is my complete right to decrease or stop exercise and that it is my obligation to inform the trainer of my symptoms. I hereby state that I have been advised and agree to inform the trainer of my symptoms should any develop.

I understand that during the performance of the program, physical touching and positioning of my body by the trainer may be necessary to assess my muscular and bodily reactions to specific exercises, as well as ensure that I am using proper technique and body alignment. I expressly consent to the physical contact for that stated reasons above.

Having such knowledge, I hereby release and hold harmless, Aaron D. Unger, Just Be Fit, Inc. and its owners, officers, agents and employees from any and all claims, demands, injuries, damages, actions or causes of actions, of whatever kind, which may arise as a result of my participation in a personal training program. I hereby assume all risks connected therewith and consent to participate in a personal fitness program. I have read this form and understand all of its terms.

Participant Signature

Fitness Specialist Signature

Print Name

Print Name

Date

Date

* If client is under 18 years of age, signature of parent or legal guardian is required.

JUST BE FIT, INC.

EXERCISE BASED REHABILITATION

PATIENT MEDICAL INFORMATION RELEASE

SIGNED _____ **DATE** _____

Dear _____ Date _____

Fax # _____

Thank you for taking your time to fill out the following brief medical clearance for your patient _____.

To design and implement an exercise program for your patient please indicate any recommendations or limitations your patient may have to appropriately begin a safe and effective exercise routine.

Please list any medications your patient is taking and the heart rate effect.

Please include Blood Pressure _____ CHOL _____

_____ has my approval to begin an exercise program with Just Be Fit with the recommendations and/or limitations stated above.

Signed _____ Date _____

Thank you for your time!

Please return medical clearance form to:

JUST BE FIT, INC.
420 Lake Cook Road, Suite 101.
Deerfield, IL 60015
Office (847) 444-1348 or Fax (847) 444-1349
www.justbefitinc.com

JUST BE FIT, INC.

EXERCISE BASED REHABILITATION

BILLING AGREEMENT

Sessions will be made by appointment at your convenience and the availability of the fitness specialist. Sessions are based on a 60-minute hour. Sessions will take place at Just Be Fit, Inc. (420 Lake Cook Road Deerfield, IL 60015). As a professional courtesy, cancellations must be made at least 24 hours before the scheduled appointment. Rehab sessions canceled inside of 24 hours of the scheduled appointment will be billed at the normal rate of a single session to the client, or clients.

Insurance Reimbursement

* Patients must have their Doctor fill out appropriate Just Be Fit Referral Form, and obtain a Doctors script explaining exact treatment and diagnosis.

* Each patient has to pre pay for a specific rehabilitation package.

* When sessions are completed from specific package, patient will be given copies of services rendered, and an invoice with treatment dates included ICD-9 diagnosis code(s) and treatment codes.

* Patients are responsible for submitting their own insurance claims.

A refund will be given only with the written consent of Just Be Fit, Inc. under the following circumstances:

1. A patient relocates to another city or location out side the counties of Cook, Lake or Du Page Illinois.
2. The Medical condition a patient suffers from makes it impossible to continue with their fitness specialist. In this case, a physician's written notification is required.

Sessions which remain unused for a period of one (1) year after the date of purchase will not be honored.

I, _____, have read, understand and accept these policies as they are related to rehabilitation training procedures with my trainer.

Acknowledged and Agreed,

Client

Date

Witnessed,

Fitness Specialist

Date

Rehabilitation Programs

# OF SESSIONS	PRICE PER SESSION	TOTAL COST
1	\$85.00	\$85.00
5	\$80.00	\$400.00
10	\$75.00	\$750.00
20	\$70.00	\$1400.00

** First Fitness Assessment and Consultation charge \$85.00*

JUST BE FIT, INC.

EXERCISE BASED REHABILITATION

420 Lake Cook Rd, Suite 101
Deerfield, IL 60015
Ph 847-444-1348 Fax 847-444-1349

PHYSICIAN / THERAPIST REFERRAL FORM I

I Instructions to Physician/Therapist

1. Complete patient name and information in Section II
2. Complete your name and information in section II
3. Please include all known diagnoses by ICD-9 code. If BWC case, please include claim number. If precertification is required, please include code/number.

II Patient Name: _____ Phone: _____
Physician/Therapist Name: _____ Phone: _____
Diagnosis (ICD-9): _____ BWC Claim # _____ Precertification Code # _____

III Patient Category

- | | |
|---|--|
| <input type="checkbox"/> Post Physical Therapy/Rehabilitation | <input type="checkbox"/> Geriatric |
| <input type="checkbox"/> Sedentary | <input type="checkbox"/> Prepubescent Adolescent |
| <input type="checkbox"/> First-Time Exerciser | <input type="checkbox"/> Pre-Surgery on ____/____/____ |
| <input type="checkbox"/> Weight Loss | <input type="checkbox"/> Poor Balance and Unstable |
| <input type="checkbox"/> Weight Gain | <input type="checkbox"/> Gait Dysfunction |
| <input type="checkbox"/> Post-Surgery on ____/____/____ | <input type="checkbox"/> High-Risk Factors CAD |
| <input type="checkbox"/> Inflexibility | <input type="checkbox"/> Sport |

Specific _____

- | | |
|---|--|
| <input type="checkbox"/> Posture/Standing Alignment | <input type="checkbox"/> Diabetes Type _____ |
|---|--|

IV Requested Service(s)

- | | |
|--|--|
| <input type="checkbox"/> Consultation | <input type="checkbox"/> Posture Training |
| <input type="checkbox"/> Adherence Risk Profile | <input type="checkbox"/> Stress Control/relaxation Program |
| <input type="checkbox"/> Pre-Exercise Assessment | <input type="checkbox"/> Nutrition Review |
| <input type="checkbox"/> Exercise Program Design | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Muscle Balance Testing | |

V Medications

VI _____ has my approval to begin the above services with the recommendations and contraindications stated above. Please (circle one – cross out other)

- I would / would not like to pursue insurance reimbursement.
I would / would not like to receive progress reports every _____ weeks.

Physician/Therapist Signature _____ License # _____ Date _____

PLEASE FAX TO (847) 444-1349 WHEN COMPLETE. THANK YOU.

JUST BE FIT, INC.

EXERCISE BASED REHABILITATION

420 Lake Cook Rd, Suite 101
Deerfield, IL 60015
Ph 847-444-1348 Fax 847-444-1349

THERAPIST REFERRAL FORM II

Initial Evaluation

Patient Name _____ Date of Birth _____
Diagnosis _____ Date of Progress Evaluation _____
Referring Physician _____ Date of Onset _____

Subjective:

Treatment: AROM/ POROM/ AAROM/ Strength Training/ Posture Training/ Trunk Stab. Ex Closed Kinetic Chain Strengthening/ Modalities including: _____

Home Exercises Instruction for: _____

Objective reports:

1) Range of Motion:	AROM	PROM	2) Strength
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

3) Palpation _____

4) Special Testing/Functional Impairment _____

Assessment:

Prognosis:

Goals:

Short term to be achieved in _____ weeks.

- 1) _____
- 2) _____

Long term to be achieved in _____ weeks.

- 1) _____
- 2) _____

Plan:

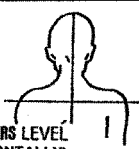
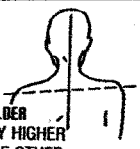
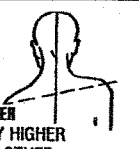
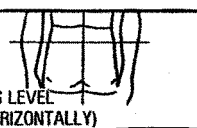
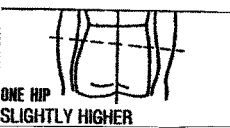
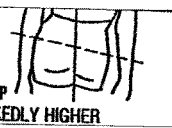



Thank you for this referral.

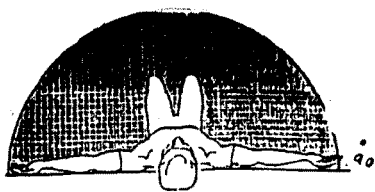
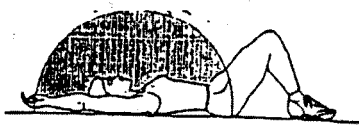
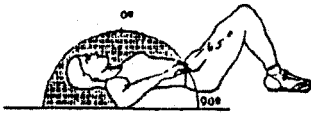
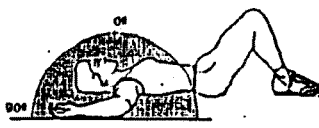
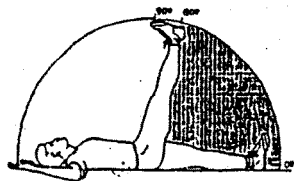

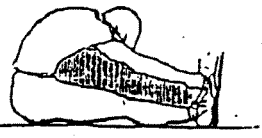
Sincerely,

JUST BE FIT, INC.

EXERCISE BASED REHABILITATION

Clients Name: _____

Training Assessment		Date:		Trainer:	
Components Cardiovascular Aerobic	RHR	THR	RPE(1-10)	BP	
	Mode	Intensity	Duration		
 SHOULDERS LEVEL (HORIZONTALLY)	 ONE SHOULDER SLIGHTLY HIGHER THAN THE OTHER	 ONE SHOULDER MARKEDLY HIGHER THAN THE OTHER			
 HIPS LEVEL (HORIZONTALLY)	 ONE HIP SLIGHTLY HIGHER	 ONE HIP MARKEDLY HIGHER			
 LOWER BACK NORMALLY CURVED	 LOWER BACK SLIGHTLY HOLLOW	 LOWER BACK MARKEDLY HOLLOW			
Posture Head Fwd _____ Sway back _____ Shoulders: Higher R / L _____ Shld rounded _____ Pelvic tilt _____ Hips: Higher R / L _____ Kyphosis _____ Knees hyperextended _____ Feet flat _____					
GONIOMETRIC ASSESSMENT					
MOTION	NORMAL	RIGHT	LEFT	COMMENTS	
	AVG.				
	AVG.				
	AVG.				
	AVG>				
	AVG.				
	AVG.				
Injury / Illness	Musculoskeletal Risk Factor: ___ no risk, ___ at risk, ___ high risk, ___				
Goals and Plan	Exercise suggestions for Trainer				

Flexibility
 Shoulder Abductors
 Shoulder Flexors
 Shoulder Internal Rotators
 Shoulder External Rotators
 HAMSTRINGS
 Hip Flexors
 Back Extensors

Just Be Fit Inc.

REHABILITATIVE RECORD

Patient Name: _____
 Phone Number: _____
 AGE/DOB: _____
 Physican: _____
 Date Entered Program: _____
 Insurance: _____ Codes: _____
 Copay: _____
 # of Treatments: _____
 Re- evaluation: yes no
 Date: _____
 Therapist assigned: _____
 Modalities: _____

Date	Procedure	Date	Procedure	Date	Procedure

Diagnosis: _____

Cardiovascular (warmup):									

ROM (stretching) Exercises:									

Flexibility and Posture:									

Strengthening Exercises:									

Monthly Progress:		Goals:	