Medical Waiver and Liability Form

Client's Name: _____ **Age**: _____ **Date:** _____

In the event of a medical emergency, the following people and emergency medical personnel should be contacted:

Doctor: _____ **Phone:** _____

Hospital Preferred: _____

Medications Taken: _____

Allergies: _____

Emergency Contact 1: _____

Phone: _____ Phone (2): _____

Relationship: _____

Emergency Contact 2: _____

Phone: _____ Phone (2): _____

Relationship: _____

In the event where I (or my spouse) cannot be contacted, I authorize Acceleration Sports to secure whatever medical care is necessary for the safety and well-being of the client. I will assume all costs incurred for emergency care.

_____ _____

SIGNATURE of Consenting Individual (if 18 years of age or older), Parent or Guardian **Date**

Medical History Form (Confidential)

Client's Name: _____
Last First MI

I. Past Injuries: Do you have, or have you ever had, any of the following conditions? If so, please check the blank and state how old you were when at the time of occurrence:

☐ Concussion(s) (number) _____
☐ Skull fracture(s) (number)_____
☐ Neck injuries_____
☐ Shoulder injuries _____
☐ Elbow injuries _____
☐ Arm/wrist/hand injuries _____
☐ Rib cage injuries_____
☐ Back injuries_____
☐ Hip injuries_____
☐ Thigh injuries _____
☐ Knee injuries _____
☐ Lower leg injuries/ "shin splints" _____
☐ Ankle injuries _____
☐ Foot injuries _____
☐ Muscle strains (pulls) _____
☐ Any injury to any part not mentioned?_____
☐ False teeth or bridge? _____
☐ Ever had an arthroscopy? What joint? _____
☐ Ever been advised to restrict activity during the past 5 years?_____

II. Past Illness Or Medical Problems: Do you now have, or have you ever had, any of the following conditions? If so, please check the blank and state how old you were when at the time of occurrence:

☐ Surgical operations:_____
☐ Confinement to hospital _____
☐ Frequent headaches _____
☐ Fainting spells, dizziness or weakness _____
☐ Weakness or illness when exposed to high temperatures _____
☐ Epilepsy or convulsions _____
☐ Numbness or tingling _____
☐ Nosebleeds _____
☐ Difficulty hearing _____
☐ Heart murmur _____
☐ Arthritis _____
☐ Diabetes (type) _____
☐ Any abnormal bleeding tendencies _____
☐ Any allergies---food _____
---drugs/medicines _____
---skin _____
---asthma_____
☐ Loss of, or serious impairment of, a paired organ (eg.,kidney, eye, lung) _____
☐ Osgood-Schlatter's disease of the knee_____
☐ Hepatitis _____
☐ Acquired immune deficiency syndrome (AIDS)_____
☐ Infectious mononucleosis (mono) _____
Anything not mentioned? _____
_____

_____ _____
SIGNATURE of Consenting Individual (if 18 years of age or older), Parent, or Guardian **Date**

Client Agreement *(page 1 of 2)*

These terms govern Your Acceleration Sports agreement ("Agreement"). As used in this Agreement, "Client" means the person becoming a Client; "You" or "Your" also means the Client, but includes the Responsible Party if the Client is less than 18 years old; the "Responsible Party" is the Client's parent or other adult who is legally responsible for the Client; and "We" or "Our" means the Acceleration Sports owner. *By signing below, You agree to all the terms and conditions in this Agreement and certify that You have read all pages of the entire Agreement, so please read it carefully.*

Participation; Scheduled Training Sessions.

The extent to which the Client participates in functional nutrition session, holistic health session, exercise, and other activities is his or her decision alone. If the Client fails to attend a scheduled session or is more than fifteen minutes late for that session, we may retain the right to not credit you with an additional session. You must cancel any scheduled session at least 24 Hours in advance.

Client's Physical Fitness.

You represent that the Client is physically fit to engage in the activities that he or she participates in. You are solely responsible for all health risks associated with those activities. If We evaluate the Client's physical fitness or recommend any activities for the Client, that is not a substitute for—and does not relieve You from the obligation of—having the Client's doctor evaluate the Client or recommend appropriate activities for him or her before the Client begins a physical exercise program or engages in any activities with Acceleration Sports. The Client should be examined by his or her physician before training begins. The Client should consult with his or her physician regularly during the time that the Client is engaging in activities. If the Client has a history of heart disease, the Client ***must*** consult a physician before training begins. He or she may not begin training or join without such a consultation. We are not licensed doctors and our advice is therefore limited in scope and is not a substitute for medical supervision and advice, which the Client must obtain independently of us.

Disclaimer of Liability.

Acceleration Sports is not a physician or a psychologist, and the scope of Our consultation services does not include treatment of diagnosis of specific illnesses or disorders. If You suspect you may have an ailment or illness that may require medical attention, then you are encouraged to consult with a licensed physical without delay. Only a licensed physician can prescribe drugs. Any mention of drugs in the course of consultation is only for the purpose of provide a complete history of drugs that the client is taking and not for Acceleration Sports to judge the appropriateness of the medication. Any change in prescription or dosage is a decision the client makes with his or her physician.

Rather than dealing with the treatment of disease, Acceleration Sports focuses on wellness and prevention of illness through the use of non-toxic, natural nutritional therapies to achieve optimal health. As a Certified Nutrition Specialists and Certified Holistic Health Coach, We primarily educate and motivate clients to assume more personal responsibility for their health by adopting a healthy attitude, lifestyle, and diet. While people generally experience greater health and wellness as a result of embracing a healthier attitude, lifestyle, and diet, We do not promise or guarantee protection from future illness.

Assumption of Risk/Waiver.

Using Acceleration Sports involves the risk of injury to You or Your guest, whether You or someone else causes it. Specific risks vary from one activity to another and the risks range from minor injuries to major injuries, such as catastrophic injuries. **In consideration of Your participation in the activities offered by Acceleration Sports, <u>You understand and voluntarily accept this risk and agree</u> that Acceleration Sports, employees, volunteers, and representatives (the "Acceleration Sports Group") <u>will not be liable for any</u> injury <u>whether related to exercise or not</u>. By signing below, You acknowledge and agree that You have read the foregoing and know of the nature of the activities of Acceleration Sports and You agree to all the terms on all pages of this Agreement and acknowledge that You have received a copy of it.**

_____ **Please Initial**

Client Agreement Continued *(page 2 of 2)*

By signing this Agreement *(page 1 and page 2)*, Client acknowledges that Acceleration Sports is a health consultant and not a physician, and that you should see a doctor if you think you have a medical condition, Client or Responsible Party is of legal age, has received a filled-in and completed copy of this Agreement identifying the services purchased, has read and understands the entire Agreement, the Assumption of Risk/Waiver, and all other terms and conditions. We will not he held liable for failure to diagnose or treat an illness, nor will we be liable for failure to prevent future illness.

Additionally, You promise to give Acceleration Sports a complete and accurate account of any medical conditions that you may have and any medications that you are taking.

If You, the Client, have any comments or questions, please call or email Stacy Peterson at call 805.704.7193 or stacy@accelerationsports.net.

Late or Returned Item Charges.
We may charge You a $45.00 fee for any returned checks resulting from insufficient funds, account closed, or similar circumstance.

Acceleration Sports (staff): _____
Signature

Client's Name: _____ **Client's Signature:** _____
Print Name **Signature**

If Client is under 18 years old, Responsible Party's Signature:

_____ **Date:** _____
Signature

Confidential Health Intake Form

Please print clearly

Client Information

Name _____ Date _____

Address _____

Email _____

How did you hear about us? (friend, website, specific ad, another healthcare provider) _____

How often do you check email? _____ Is it ok to communicate with you via text? Y ☐ N ☐

Telephone – Cell _____ Day _____ Night _____

Would you like to be included in my nutrition and fitness email newsletter? Y ☐ N ☐

Statistics

Age _____ Height _____ Gender _____ Date of Birth _____ Place of Birth _____

Weight at Birth _____ Current weight _____ Weight six months ago _____ One year ago _____

Would you like your weight to be different? _____ If so, what? _____

Family/Living Status? _____ Relationship status _____

Children _____ Pets _____

Occupation _____ Hours of work per week _____

How is/was the health of your mother? _____

How is/was the health of your father? _____

What is your ancestry? _____ What blood type are you? _____

History

Have you lived or traveled outside of your Country of Residence? If so, where and for how long?

_____

Have you or your family recently experiences any major life changes? If so, please comment:

_____

Have you experienced any major losses in life? If so, please comment:

_____

How much time have you taken off work/school in the last year?

☐ 0-2 days ☐ 3-14 days ☐ More than 15 days

Health Concerns

1. Please list your 3 main health concerns (describe in detail including the severity of the symptoms).

_____

_____

_____

2. When did you first experience these concerns?

_____

3. How have you dealt with these concerns in the past? ☐ doctors ☐ self-care ☐ other Please list:

_____

4. Have you experienced any success with these approaches? If so, which one(s).

_____

5. What do you believe is the cause of your number one above mentioned health concern (question #1 above)?

_____

_____

6. What other health practitioners are you currently seeing? List name, specialty, and phone number below.

_____

_____

7. How often did/have you taken antibiotics as:

a) a(n) infant/childhood? b) a teenager? c) an adult?

8. List any medicine you are currently taking or should be taking (brand name, amount, date started):

_____

_____

_____

9. List all vitamins, minerals, herbs, and nutritional supplements you are currently taking (brand name, amount, date started taking):

_____

_____

_____

10. Please check (√) any of the following that you take:

- ☐ Antacids (Rolaids, Tums)
- ☐ Antihistamines (Claritin, Benadryl)
- ☐ Cortisone (cream or pills)
- ☐ Cough and cold medications
- ☐ Diet pills, appetite suppressants
- ☐ Laxatives
- ☐ Pain relievers (Tylenol, Aleve, Aspirin, Motrin)
- ☐ Sleeping pills
- ☐ Thyroid Medication
- ☐ Oral contraceptives or HRT

11. Any family members have similar health concerns that you are experiencing (please describe)?

_____

_____

Nutritional

12. What foods did you eat often as a child?

Breakfast

_____

_____

_____

Lunch

_____

_____

_____

Dinner

_____

_____

_____

Snacks

_____

_____

Liquids and amounts

_____

13. What is your food like these days?

Breakfast

_____

_____

_____

Lunch

_____

_____

_____

Dinner

_____

_____

_____

Snacks

_____

_____

Liquids and amounts

_____

14. Are there any foods you avoid due to the way they make you feel? If so, please name the food and the symptom.

_____

_____

15. Do you have symptoms immediately after eating like bloating, gas, sneezing or hives? If so, please explain.

_____

_____

16. Are you aware of any delayed symptoms after eating certain foods such as fatigue, muscle aches, sinus congestion, etc? If so, please explain.

_____

17. Are there food that you crave? If so, please explain.

_____

18. Describe your diet at the onset of your health concerns.

_____

_____

19. Do you have any known food allergies or sensitivities?

_____

_____

20. Which of the following foods do you consume regularly?

- ☐ Soda
- ☐ Diet Soda
- ☐ Refined Sugar
- ☐ Alcohol
- ☐ Fast Food
- ☐ Gluten (wheat, rye, barley)
- ☐ Dairy (milk, cheese, yogurt)
- ☐ Coffee

21. Are you currently on a special diet?

- ☐ Blood Type
- ☐ Dairy restricted or dairy-free
- ☐ Diabetic
- ☐ Gluten-free
- ☐ Ovo-lacto
- ☐ Paleo
- ☐ Raw
- ☐ Refined sugar-free
- ☐ Vegan
- ☐ Vegetarian
- ☐ Ketogenic
- ☐ Other (please describe)

22. What percentage of your meals are home-cooked (home-cooked = non pre-packaged meals)?

- ☐ 10
- ☐ 20
- ☐ 30
- ☐ 40
- ☐ 50
- ☐ 60
- ☐ 70
- ☐ 80
- ☐ 90
- ☐ 100

23. Is there anything more than we should know about your current diet, history, and relationship with food?

_____

_____

Intestinal

24. Bowel movement frequency

- ☐ 1-3 times per day
- ☐ more than 3 times per day
- ☐ not regularly every day

25. Bowel movement consistency

- ☐ soft and well formed
- ☐ often float
- ☐ constipation
- ☐ diarrhea
- ☐ thin, long, and narrow
- ☐ small and hard
- ☐ loose but not watery
- ☐ alternating between hard and loose stool

26. Bowel movement color

- ☐ medium brown
- ☐ very dark or black
- ☐ greenish
- ☐ blood is visible
- ☐ variable
- ☐ yellow, light brown
- ☐ chalky colored
- ☐ greasy, shiny

27. Do you experience intestinal gas? If so, what time of day? Is it's excessive, occasional, odorous, etc?

_____

Medical

28. Please check all of the following conditions / symptoms that apply to your **current situation or past history** AND a **brief description of your symptoms, chosen treatment(s), and date(s) of condition**.

- ☐ Cancer _____
- ☐ Hepatitis _____
- ☐ Heart Disease _____
- ☐ Venereal Disease _____
- ☐ Diabetes _____
- ☐ High Blood Pressure _____
- ☐ High Cholesterol _____
- ☐ Kidney Disease _____
- ☐ Thyroid Disease _____
- ☐ Depression _____
- ☐ Asthma _____
- ☐ Allergies _____
- ☐ Anemia _____
- ☐ Chronic Yeast Infections _____
- ☐ Hemorrhoids _____
- ☐ Autoimmune Disease _____
- ☐ ADHD / ADD _____
- ☐ Allergies _____
- ☐ Chronic Colds _____
- ☐ Chronic Constipation _____
- ☐ Crohn's Disease _____
- ☐ Depression _____
- ☐ Anxiety _____
- ☐ Fatigue _____
- ☐ Gastrointestinal Disorder _____
- ☐ Inability to sleep _____
- ☐ IBS or IBD _____
- ☐ SIBO _____
- ☐ Ulcerative Colitis _____
- ☐ PMS _____
- ☐ Eating Disorder _____
- ☐ Other _____

Health Hazards

29. Have you been exposed to any chemicals or toxic metals (lead, mercury, arsenic, aluminum)?

_____

30. Do odors affect you? _____

31. Have you or due you currently smoke? Are you or have you been exposed to second-hand smoke for any length of time? _____

32. Do you have mercury amalgam fillings? If so, how many? _____

Lifestyle History

33. Have you had periods of eating junk food, binge eating or dieting? List any known diet that you have been on for a significant amount of time.

_____

_____

34. Have you consumed, used, or abused alcohol, drugs, meds, tobacco, or caffeine? Do you still?

_____

_____

35. What role does exercise play in your life? How often do you engage in physical exercise per week? What types?

_____

_____

36. How do you handle stress? In what ways do you relieve stress?

_____

_____

37. Describe your sleep patterns. Can you get to sleep easily? Can you stay asleep? What time do you on average go to bed and get up?

_____

_____

For Women Only

38. How are/were your menses? Do/did you have PMS? Painful periods? If so, explain.

_____

_____

39. In the second half of your cycle, do/did you experience any symptoms of breast tenderness, water retention, or irritability?

_____

40. Are your periods regular? Y ☐ N ☐ 41. How many days is your flow? _____ 42. How frequent? _____

43. Have you experienced any yeast infections or urinary tract infections? How often would you say you have them?

_____

44. Have you/do you still take birth control pills? If so, please list brand name, length of time, and type.

_____

_____

45. Have you had any problems with conception or pregnancy? If so, when?

_____

46. Are you taking any hormone replacement therapy or hormonal supportive herbs? If so, please list again here.

_____

_____

Mental Health For All

47. How are your moods in general? Do you experience more than you would like of anxiety? Depression? Anger?

_____

_____

48. From 1-10, one being the worst and 10 being the best, describe your usual level of energy.

_____

49. At what point in your life did you feel best? Why?

_____

_____

Other

50. Do you think family and friends will be supportive of you making health and lifestyle changes to improve your quality of life? If no, explain.

_____

_____

51. Who in your family or on your health care team will be most supportive of you making dietary change?

_____

52. Please describe any other information you think would be useful in helping to address your health concern(s).

_____

_____

53. What are your health goals and aspirations?

_____

_____

_____

_____

54. Though it might seem odd, please consider why you might want to achieve these health goals for yourself.

_____

_____

_____

_____

_____