

PERSONAL TRAINING HEALTH HISTORY

Name: _____
First
Middle
Last

Address: _____
Street
Apt
City
State
Zip

Home Phone: _____ Cell Phone: _____ Email address: _____

Date of Birth: _____ Gender: _____ Marital Status: _____ Employment: Full-Time Part-Time Student Retired

Who may we thank for referring you? _____

Primary Care Physician: _____
Name
Phone

In case of an emergency, please call: _____
Name
Relationship

_____ Street Apt City State Zip Phone

MINORS ONLY: List guardian names, addresses and contact information.

_____ Name Street State Zip Phone

_____ Name Street State Zip Phone

Have you ever done personal training? YES NO Last Session Date: _____

FITNESS GOALS: Please describe any goals, your current exercise routine, or any other medical conditions that may limit your full participation in an exercise program?

CURRENT MEDICATIONS: Please list all physician prescribed medication, over-the-counter medication, nutritional supplements, herbal or homeopathic remedies that you have taken within the last three months.

NAME	DATE BEGAN	DOSAGE	REASON FOR TAKING
1.			
2.			
3.			
4.			

Do you smoke, use chewing tobacco, or other related products? YES NO

Age Began: _____ Age Quit: _____ Cigarettes/day: _____

Please describe your typical diet in the chart below. Include beverages such as water, soda, tea, coffee, or alcohol.

BREAKFAST	SNACK	LUNCH	SNACK	DINNER	SNACK

MUSCULOSKELETAL CONDITIONS: Place an X in the appropriate box, if you are experiencing any of the following:

- | | | |
|--|--|--|
| <input type="checkbox"/> Ankle Pain | <input type="checkbox"/> Foot Pain | <input type="checkbox"/> Muscle Weakness |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Hand/Wrist Pain | <input type="checkbox"/> Neck Pain |
| <input type="checkbox"/> Body Aches | <input type="checkbox"/> Hip Pain | <input type="checkbox"/> Shoulder Pain |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Knee Pain | <input type="checkbox"/> Swelling |
| <input type="checkbox"/> Difficulty Standing/Walking | <input type="checkbox"/> Muscle Spasm | <input type="checkbox"/> Radiating Pain |

What is your main musculoskeletal complaint & when did this condition begin? _____

How frequent and for how long do you experience pain? _____

Does your pain limit your daily or recreational activities in any way? _____

What is the intensity of the pain from a scale of 1-10? 1 2 3 4 5 6 7 8 9 10

Please rate your overall stress level on a scale of 1-10: _____

HEALTH HISTORY: Please complete the following health history chart for yourself by placing an X in the appropriate box.

CONDITION	X	CONDITION	X
Allergies		Headaches/Migraines	
Arthritis		High Blood Pressure	
Asthma		High Cholesterol	
Broken Bone or Fracture		Joint Swelling	
Cancer or Tumors		Multiple Sclerosis	
Chronic Fatigue Syndrome		Osteoporosis	
Diabetes		Parkinson's Disease	
Fibromyalgia		Significant Trauma/Injury	
Gastrointestinal Disorder		Seizures/Epilepsy	
Heart Disease		Varicose Veins	
Surgery/Description:		Other (Please Specify)	
Date:			

Are you currently pregnant? Yes No If Yes, how many weeks? _____

Is this a high risk pregnancy? Yes No Please explain: _____

Are you currently nursing? Yes No Are you less than six weeks post-partum? Yes No

Signature of client or legal guardian: _____ Date: _____

PERSONAL TRAINING RELEASE OF LIABILITY

I have enrolled and I am participating in a health and fitness program of physical activity, which may include cardiovascular activity, strength training, and stretching with _____ [For Office Use Only].

I hereby waive, _____ [For Office Use Only], the personal trainer, or any persons involved in this program from any and all liability from injuries and damages resulting from participation in any activities or use of equipment or machinery involved in this fitness program.

I fully understand that the program may be strenuous and I choose to participate completely voluntarily. I affirm that I am physically sound and suffering from no condition, impairment, or disease that would prevent my participation or use of equipment in this program. I acknowledge that I have had a physical examination and been given my physician's approval to participate or have decided to participate in this program and use the equipment without the approval of my physician. I understand that personal training is not a substitute for medical attention, examination, diagnosis or treatment. Additionally, I understand that personal training is not recommended and is not safe under certain medical conditions.

I will advise my personal trainer about any significant health issue or condition, including injuries, and pregnancy before I begin this program. I understand that from time to time, I will receive "hands-on" assistance during personal training sessions from the personal trainer, in a manner that is safe and appropriate, and I am comfortable with this aspect of this program. My personal trainer will maintain all aspects of this program as confidential to the extent protected by the law of the Commonwealth of Massachusetts.

I have read this agreement, fully understand its terms, understand that I have given up substantial rights by signing this agreement, and have signed it freely and without any inducement or assurance of any nature. I intend it to be a complete and unconditional release of all liability to the greatest extent allowed by law and agree that if any portion of this agreement is held to be invalid, the balance, notwithstanding, shall continue in full force and effect.

Name: _____

Address: _____

Email: _____ Phone: _____

Signature: _____ Date: _____

PERSONAL TRAINING RELEASE OF LIABILITY

PARENTAL CONSENT (if participant is under the age of 18)

AND I, the minor's parent and/or legal guardian, understand the nature of this personal training program and the minor's experience and capabilities and believe the minor to be qualified to participate in such activity. I have read this agreement, fully understand the terms, understand that I have given up substantial rights by signing this consent and I have signed this consent freely and without any inducement or assurance of any nature and intend it to be a complete and unconditional release of all liability to the greatest extent allowed by law and agree that if any portion of this agreement is held to be invalid, the balance, notwithstanding, shall continue in full force and effect.

Printed Name of Parent/Guardian:

Name: _____

Address: _____

Email: _____ Phone: _____

Signature: _____ Date: _____

PERSONAL TRAINING PACKAGES & 24-HOUR CANCELLATION POLICY

The fee structure for personal training packages reduces the price of each session and is paid in advance to the facility. I realize that should I purchase such a package, there is no refund or credit should I not use all sessions included in this package. I am aware of and accept these policies noted above. I understand that if I schedule an appointment for a personal training session, I will be responsible for the full charge of the personal training session should I need to cancel and do not provide a 24-hour notice prior to the scheduled appointment.

Signature: _____ Date: _____

OMBE Privacy Policies Notice

This notice describes how your medical information may be used and disclosed, how you can access this information, and how your privacy is being protected at OMBE. OMBE, all health care providers at OMBE, and all associates providing service at OMBE are required by law to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information. The privacy of your medical records is important to us and we are committed to protecting your medical records. We create a record of the services you receive at OMBE in a paper chart and on a computer. We need this record to provide you with quality care and to comply with certain legal requirements. In order to maintain the service level that you expect from a health care office, we may need to share limited personal medical and financial information. Your medical records are the property of this health care office, but the information in the medical record belongs to you. This notice also describes your rights and certain duties we have regarding the use and disclosure of medical information.

How OMBE May Use or Disclose Your Health Information

Treatment: We use medical information about you to provide your health care. We may disclose your health care information to other health care providers within our practice for the purpose of treatment, payment or health care operations. On occasion, it may be necessary to seek consultation regarding your condition from other health care providers associated with OMBE. We may share your medical information with other physicians or other health care providers who will provide services that we do not provide. We may share this information with a physician who will need to treat you, or a laboratory that performs a test.

Payment: We use and disclose medical information about you to obtain payment for the services we provide. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you. For example, we may disclose your health information to your insurance provider or a third party for the purpose of payment, to receive prior approval, or to determine whether your plan will cover the treatment.

Workers' Compensation: We may disclose your health information as necessary to comply with State Workers' Compensation Laws.

Health Care Operations: We may use and disclose medical information about you to operate this health care practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence, and qualifications of our staff. We may also use and disclose this information as necessary for medical reviews, legal services, and audits, including fraud detection and compliance programs. We may also share your medical information with our "business associates", such as our appointment scheduling and billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them to protect the confidentiality of your medical information. We may also disclose information to doctors, nurses, technicians, medical students, and other personnel for review and learning purposes. Additionally, the health care practice has an open waiting room where patients may be seen by other patients. The secure area around the front desk also has a computer and fax machine that may be visible to the public. This area is limited to OMBE staff and health care providers only and the computer has an automatic screen saver that is activated after two minutes without activity.

Appointment Reminders: We may contact you for appointment reminders. If you are not available, we may leave a message via email, a voicemail inbox, answering machine, or with the person answering your home phone. No personal health information will be disclosed during this recording or message other than the date and time of your scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment.

Notification and Communication with Family: We may disclose your health information to notify a family member or another person responsible for your care about your location and general condition in the event you are sick or injured. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures. We may disclose this information in an emergency situation.

Marketing: We may contact you to give you information about products or services, case management, care coordination, or to direct or recommend other treatments or health-related benefits and services that may be of interest to you. We do not disclose your personal contact information including your phone number or email address to any third party for marketing or solicitation.

Required by Law: When the law requires us to report abuse, neglect, domestic violence, we will comply with the relevant legal requirements. We may, and are sometimes required by local, state, or federal law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may disclose your

health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

Public Health & Safety: We may and are sometimes required by law to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury, or disability; reporting child, elder, or dependent adult abuse or neglect; and reporting domestic violence. We may disclose to the FDA, or persons under the jurisdiction of the FDA, protected health information relative to adverse events with respect to drugs, foods, supplements, products and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Special Government Functions: If you are a member of the armed forces, we may release protected health information about you if it relates to military and veteran activities. We may also release your protected health information for national security purposes, protective services for the President, and medical suitability or determinations of the Department of State.

Deceased Persons: We may disclose your health information to coroners, medical examiners, funeral directors, or organizations involved in procuring, banking, or transplanting tissues.

Change of Ownership: In the event that this medical practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.

Right to Request Special Privacy Protections: You have the right to request restrictions on certain uses and disclosures of your health information, by a written request specifying what information you want to limit in our use or disclosure. We reserve the right to accept or reject your request, and will notify you of our decision.

Right to Request Confidential Communications: You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular e-mail account or to your work address. We will comply with all reasonable communication requests submitted in writing.

Right to Inspect and Copy: You have the right to inspect and copy your health information. To access your health information, submit a written request detailing the information you want access, inspect, or copy. We will charge a reasonable fee, as allowed by federal law. We may deny your request under limited circumstances. You have the right to appeal our decision if we deny access your child's records in the case that access could cause harm to your child.

Right to Amend or Supplement: You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about OMBE's denial and how you can disagree with the denial within thirty (30) days of receipt of your written request. We may deny your request if we do not have the information, if we did not create the information, if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. You also have the right to request that we add to your record a statement of up to 250 words concerning any statement or item you believe to be incomplete or incorrect.

Right to an Accounting of Disclosures: You have a right to receive an accounting of disclosures of your health information made by this office, except that this office does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in the Treatment, Payment, Health Care Operations, Notification and Communication with Family paragraphs. Additionally, this office does not have to account for disclosures otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this office has received notice from that agency or official that providing this accounting would be likely to impede their activities.

More About OMBE's Privacy Policy

We reserve the right to amend this Privacy Policies Notice at any time in the future. Until such amendment is made, we are required by law to comply with this Notice. After an amendment is made, the revised Notice will apply to all protected health information that we maintain. You have the right to request a current copy of this Notice which is maintained on our website and at the front desk. If you would like a more detailed explanation of these rights, to exercise one or more of these rights, or submit any complaints in regards to this Notice, please contact our Privacy Officer, Jessica Molleur. If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint without the risk of penalization to: Department of Health and Human Services, Office of Civil Rights, Hubert H. Humphrey Bldg., 200 Independence Avenue, S.W., Room 509F HHH Building, Washington, DC 20201.

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OMBE Privacy Policies Acknowledgement

I have received, read, and understood OMBE's Privacy Policies Notice. I understand how this health care office and its health care providers may use or disclose my health information. I understand when this health care office may not use or disclose my health information. I understand my health information rights and understand that the office reserves the right to change the Privacy Policies Notice. I also understand how to place a complaint regarding this Notice and have also been provided the opportunity to review and question the privacy policies of this health care office.

Signature of Patient or Authorizes Representative

Date