Body Concepts Patient Information

Name: _____ If patient is a minor, name of parent _____

Address:_____ City:_____ State:____ Zip:_____

Home # _____ Work # _____ ext _____

Cell # _____ E-Mail _____

Employer _____ City _____

Birth date: _____ ☐ Male ☐ Female Social Security: _____

Marital Status: ☐ Single Married Other

Referring Physician: _____ Phone: _____

How did you hear about us? (Please be as specific as you can)

Medical Professional_____ Existing or Former Client_____

Lifestyle Group (bike, run...) _____ Advertisement/Flyers (Where?)_____

Body Concepts Clinic or Seminar_____ Event Booth (Cyclebration, Tour of CA, etc.)_____

Body Concepts Cycling Team_____ Other_____

Did you know that Physical Therapy does not require a referral from a Medical Professional? Yes No

I am also interested in: ☐ Peak Cycling ☐ Pilates ☐ Massage Therapy ☐ Chiropractic care

I desire to engage voluntarily in Body Concept Inc.'s Physical Therapy. In order to attempt to improve my physical condition, I understand that the activities are designed to place a gradually increasing workload on the cardio-respiratory and musculo-skeletal systems and thereby attempt to improve their function. The reaction of the cardio-respiratory and musculo-skeletal systems cannot be predicted with complete accuracy. These changes might include abnormalities in blood pressure and heart rate, injury to the connective tissue and musculo-skeletal systems potentially resulting in stroke, heart attack, permanent injury and possibly death.

All of Body Concept Inc.'s Staff are professionally licensed or certified in their respective fields. I understand that I am responsible for informing Body Concepts Staff of any known physical limitations, illnesses, or other physical conditions. Should any unusual symptoms occur during my time at the Body Concepts Studio facilities, I will inform a Body Concepts Staff member immediately. In addition, if I experience a change in my physical limitations, illnesses or other physical conditions or become ill outside the Body Concepts Studio facility I will inform a staff member of this change prior to resuming treatment and/or workouts on my next visit and/or contact my doctor if the symptoms warrant.

I have consulted my physician before participation in these programs and hereby represent to Body Concepts that I have their approval to engage in such activities.

In signing this consent form, I affirm that I have read this form in its entirety, that I understand the nature of the programs that I wish to participate in, and that they involve risks, as described above. I also affirm that my questions regarding the exercise, treatment and training programs have been answered to my satisfaction.

_____ _____ _____

Signature Date Print Name