Developmental Fitness Company
INCLUSION • DIRECTION • COMPASSION • CHALLENGE

SERVICE REFERRAL PACKET

GENERAL INFORMATION

Name _____

Address _____

City _____State _____Zip _____

Phone _____ Cell Phone _____

Gender _____Date of Birth _____

Email _____

EMERGENCY CONTACT INFORMATION

Parents/Guardians _____

Address _____

City _____State _____Zip _____

Phone _____ Cell Phone _____

Second Cell Phone _____ Email _____

Secondary Email _____

INSURANCE INFORMATION

Company _____

Policy Number _____

Developmental Fitness Company, LLC
PO Box 1025
North Wales, Pa 19454

Phone: 215-527-2475
E-mail: info@developmentalfitness.com
Website : www.developmentalfitness.com

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FAMILY HISTORY

Please mark if there is any family history of the following

Hypertension _____Heart Attack _____Stroke _____Cancer_____ Diabetes_____

Are both parents living ? _____ If not what cause and what age did either decease ?

_____

PERSONAL HEALTH HISTORY

____Abnormal EKG ____Seizures ____Phlebitis ____Asthma ____Kidney Issues ____Pregnancy ____Cancer

____ Emphysema ____Embolism ____ Hearing ____Autism ____Arthritis ____Hernia ____Cardiac Issues

____ Diabetes ____Cholesterol ____Thyroid ____Mental Heath ____Vision Issues ____Hypertension

____ Learning Disability ____Blood Sugar ____Nerve Damage ____Brain Injury ____Respiratory Issues

____ Neuromuscular ____ Gait ____Skin Issues ____ Falls

____ Other: _____

Explain above issues _____

_____

_____

Please check if you have any complications with the following:

____ Hand ____ Wrist ____Ankle ____ Foot ____Shoulder ____ Elbow ____ Arm ____ Back ___ Hips ____ Legs

____ Knee ____Neck ____ Head ____Fingers ____ Toes ____ Abdomen ____ Pelvis ____

____ Other : _____

Explain Above Issues _____

_____

_____

_____

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THERAPY CONCERNS

Are you or have you been under the care of Physical or Occupational Therapist for any condition ? _____

If yes, can we call them ? _____Therapist Name_____ Therapist Phone _____

Do you have a physical disability ? _____ If yes, please name _____

Do you require assistive devices ? _____If yes, please list _____

Do you have any limitations of movement ? If yes, please describe _____

_____

Please list any medical or mobility precautions that you have _____

_____

Has your doctor ever contraindicated exercise for you ? _____ If yes, please explain _____

_____

Do you have any conditions that could be aggravated by exercise ? _____ If yes please explain _____

_____

Please list all medications that you are currently taking for any condition:

Name	Dosage	Taken to control	Time Taken
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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PHYSICIANS RECOMMENDATION FORM

Physicians Name _____

Address _____

City _____State _____ Zip _____

Phone _____ Fax _____

Email _____

Please check off for those participating in our therapeutic fitness program

_____ I recommend participation without limitation

_____ I recommend participation with limitations

_____ I do not recommend participation.

_____ I have attached a prescription specifically for the services of

_____Physical Therapy

_____ Occupational Therapy

_____ Dietetics

Additional Comments or Notes _____

_____

_____

_____

_____

Physicians Signature _____

Date _____

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INFORMED CONSENT

I, _____(Name), do hereby voluntarily contract and enroll in a program of physical activity / therapy including but not limited to therapeutic exercise, neuromuscular reconditioning, manual therapy, cardiovascular conditioning, sports skills training, balance and postural conditioning, and so forth, offered by Developmental Fitness Company, LLC. I do hereby acknowledge that I have been informed of the need and the requirement for a physicians approval and/or prescription for my participation in an exercise / therapy program. I acknowledge that I have either had a physical examination conducted by a licensed medical physician with their permission/recommendation/prescription to participate. I also understand that no Developmental Fitness service will rendered until such requirements of physicians approval/recommendation/prescription is met. I hereby represent and inform Developmental Fitness Company, LLC and it representatives, that I have accurately completed all health history questions. I acknowledge and understand the risks associated with an exercise/therapy program. I do hereby assume this risk by entering into this exercise/therapy program. I also understand and acknowledge that Developmental Fitness Company will not be responsible or liable for issues resulting from physical activity done outside the direct supervision of a Developmental Fitness Company Program Representatives. With the understanding of these said elements, I therefore, voluntarily consent to engage in the Developmental Fitness Company program of (please check):

_____**Therapeutic Fitness**

_____ **Physical Therapy**

_____**Occupational Therapy**

_____**Dietetics/Nutrition**

I understand that information obtained in this written document or during the implementation of said program will be treated as privileged and confidential at all times and will consequently not be released without the expressed written consent of the undersigned and the representors. I understand the contract that I am about to enter. I acknowledge that I understand this document in its entirety or that it has been communicated or read to me if I have been unable to read or understand its form. I hereby consent to the rendition of services and procedures as explained herein by the Developmental Fitness Company program. I agree furthermore that facilities contracted by Developmental Fitness Company for my use may incur a fee for usage. I also agree to abide by all facility policies regarding the privilege of usage of the facility where services are rendered.

Signature _____ Date _____

In the witness of _____Date _____

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