

Welcome to the

ROCKWOOD

Sports Performance Program

We are looking forward to assisting you in achieving your desired fitness and sport-specific goals.

To ensure that you are able to participate at your first scheduled session the following items are required to be **completed** and **returned** to our office with all necessary signatures prior to or at that first session.

- Demographics
- Goals Sheet
- Informed Consent
- Cancellation/No Show Policy
- Medical History
- Physical Activity Readiness Questionnaire
- Privacy Practices
- Payment: Payable to RWC **

** Please do not send payments to the Main RWC billing office, due to processing that needs to occur at our office. Special arrangements for payment may be approved from SPP management.

Feel free to contact me at anytime if you have questions or concerns. We want to make sure you get the most out of your time with us.

Thanks for coming to Rockwood Clinic. Happy training!

Sincerely,

Joe Gaines ATC, AT/L, CSCS, NASM-PES
Director of Sports Performance Program
Rockwood Clinic
(509) 475-5589



Sports Performance Program

Demographics

Name: First _____ Last _____

Address: _____ E-mail: _____

Contact Phone #: _____ Gender: _____

Birth date: Month _____ Day ____ Year _____

Parent/Guardian: _____

School or Professional Team: _____ Grade in School: _____

Primary Sport for this Training Period: _____

Position in Primary Sport: _____

Secondary Sport: _____

Other Sports or Activities: _____

How did you hear about the Sports Performance Program?

Emergency Contact Information

Emergency contact person: _____

Relationship: _____

Home phone #: _____

Work phone #: _____

Cell Phone #: _____



Sports Performance Program

Goals Sheet

Please complete the following prior to your first appointment

Remember, a good goal is a SMART goal:

- Specific
- Measurable
- Action-oriented
- Realistic
- Timeline-based

My Personal Goals: _____

My Expectations of the Sports Performance Program:

Short - term steps that I will take to reach my goals:

Long - term steps that I will take to reach my goals:

Participant Signature

Date

Staff Signature

Date



Sports Performance Program

Informed Consent

I understand that:

- I will be engaging in various physical ability testing and high-intensity training sessions to evaluate and improve running speed, agility, power, strength, flexibility and balance.
- My data will be placed into a database to serve as a comparison for me and other athletes of the same age and level of participation. Also the data may be used in research reports and presentations. However, my identity will be kept completely confidential.
- The Sports Performance Program reserves the right to take and use photographs for promotional purposes with my consent.
- I am encouraged to ask questions about the procedures used in the testing and/or exercise training sessions.
- I am to notify the Sports Performance staff regarding any injury, change in current physical condition or unusual discomfort/pain immediately.
- For my safety, it is essential that the information I provide regarding my current physical condition be true and correct.
- The Sports Performance Program takes place in a facility that provides many therapy and wellness services. Therefore, I am expected to respect all patrons, staff and equipment.
- Inappropriate behavior will not be accepted.

Risks and Discomforts:

The possibility does exist that I may become injured during the testing and/or training. That is, I may develop muscle sprain or strain or muscle soreness during or after the testing and/or training periods. In very rare instances I could experience abnormal blood pressure, fainting, disorders of the heartbeat, heart attack, stroke and even death. Every effort will be made to minimize these abnormalities by observation and seeking feedback during the workouts. Emergency procedures and trained personnel are available to deal with any unusual situation that may arise.

Refund Policy:

In the event that the athlete cannot complete the program due to medical reasons, a pro-rated refund will be given. This refund will be for medical reasons **only** and must accompany a written refund request and a letter from the doctor.

Cancellation/No-Show Policy:

Due to the high demand for select appointment times and staffing concerns, it is extremely important to us that you are here for your scheduled appointments. We require 24 hour notice on all cancellations in order to better accommodate appointments for all our clients. Each client will be allowed 1 cancellation. All additional no-shows and same day, unauthorized cancellations will result in a loss of that session. We understand that there are extenuating circumstances, so additional cancellations may be approved by our staff on a case-by-case basis.

Freedom of Consent:

I have read this form and hereby agree to the policies listed above. **I understand and freely consent to participate voluntarily in all of the described physical ability tests and training and recognize the risks associated with such activities.** I understand that I may stop the individual tests and/or training sessions at any time.

(Signature of Participant)

(Date)

(Signature of Parent: If under 18 years of age)

(Date)



Sports Performance Program

Cancellation / No Show Policy

Due to the high demand for select appointment times, it is extremely important to us that you are here for your scheduled appointments. We require 24-hour notice on all cancellations in order to better accommodate appointments for all SPP clients.

Each client will be allowed (1) cancellation. All additional no-shows and same day, unauthorized cancellations will result in a loss of that session.

If a participant is a member of a group that is receiving a price discount, failure of an individual to show for a scheduled session will result in a loss of that session for the individual (i.e., that miss cannot be made up at a later date).

There will be no adjustment in the price of the program for misses by an individual.

We understand that there are extenuating circumstances, so additional cancellations may be approved by the Sports Performance Program staff on a case-by-case basis. If you have any questions about any aspect of our program, please ask a staff person and we will be happy to provide you with the necessary information.

I understand and agree to the above statements.

(Signature of Participant)

(Signature of Parent: If under 18 years of age)

ROCKWOOD

Sports Performance Program Medical History

Name: _____ Age: _____ Date: _____

Have you ever experienced...

Cardiovascular Disease:

Heart arrhythmias	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>
Chest Pain	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>
Peripheral Vascular Disease	<input type="checkbox"/>	Allergies	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	Anemia	<input type="checkbox"/>
Other	_____		

Pulmonary Disease:

Emphysema
Asthma
Other _____

Other:

Convulsions	<input type="checkbox"/>	Fainting	<input type="checkbox"/>
Heat injury	<input type="checkbox"/>	Stress Fractures	<input type="checkbox"/>
Shin Splints	<input type="checkbox"/>	Concussion	<input type="checkbox"/>
Other	_____		

Do you take any over-the-counter medications on a regular basis? Yes No

Explain: _____

Are you presently taking any prescription medications? Yes No

If yes, what medication and amount: _____

Were you ever advised to wear a brace during competition? Yes No

Explain: _____

Please list any **Surgeries, New Medical diagnoses, or Hospitalizations** and dates:

Have you ever sustained an injury to:

Wrist	<input type="checkbox"/>	Elbow	<input type="checkbox"/>
Neck	<input type="checkbox"/>	Shoulder	<input type="checkbox"/>
Knee	<input type="checkbox"/>	Ankle	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	Back	<input type="checkbox"/>
Joint Injury	<input type="checkbox"/>	Hip	<input type="checkbox"/>

other _____

Was it treated by a physician? Yes No If so, when: _____

Date of last physical exam: _____

Metabolic Disorders:

Diabetic
Hypoglycemia
Other _____

Family History: Heart disease: ___ Mother ___ Father Stroke: ___ Mother ___ Father

Other habits: Tobacco, Caffeine, Controlled Substance, Other _____

Allergies (drug, food, etc.): _____

