



Client Application

Send the following completed application to:

Email: chriscorpuz@renew-health.com
Fax: (619) 858-2210

Mailing Address:
PO Box 12817
San Diego, Ca 92112

This application *must be filled out completely*. Information contained on this application will remain confidential. Once your application is reviewed, we will contact you. If applicant is under the age of 18, a parent or legal guardian must sign this application.

NOTE: Completion of this application does not guarantee your participation in our program.

Personal and Contact Information (All information is required)

Date: _____
Full Name: _____
Date of Birth: _____ Age: _____
Address: _____
City: _____
State: _____ Zip Code: _____
Home Phone: _____
Cell Phone: _____
Email (Required): _____

In case of emergency, please notify:

Name: _____ Relationship: _____
Phone (home): _____ Phone (work): _____

Medical Information

Height: _____ Weight: _____ Sex: _____

Ailment:

Back Pain Fall Prevention Posture Arthritis Other: _____

Have you had any recent hospitalizations (within the last 12 months) _____

If "yes", then list dates and reasons: _____

Please answer Yes or No to the following. Indicate "Yes" for those that apply to you at present or have applied to you in the past:

Do you have:

Ability to breathe on your own: YES NO

History of chest pain: YES NO

History of heart disease or any other heart/valve disorder: YES NO

Any chronic illness or condition: YES NO

If yes, please explain: _____

High Blood Pressure:	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Low Blood Pressure:	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Difficulty with physical exercise:	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Osteoporosis: (Sever bone loss)	<input type="checkbox"/> YES	<input type="checkbox"/> NO
History of Pathological fracture:	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Advice from your doctor not to exercise:	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Recent surgery	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Pregnancy (now or within the last 3 months):	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Breathing/Lung Problems:	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Asthma:	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Any other disease of the lungs:	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Muscle, joint or back disorder, or any previous injury still affecting you:	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Diabetes:	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Thyroid condition:	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Cigarette smoking:	<input type="checkbox"/> YES	<input type="checkbox"/> NO
If yes, how many packs per day? _____		
High Cholesterol:	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Obesity:	<input type="checkbox"/> YES	<input type="checkbox"/> NO
History of heart problems in the immediate family:	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Hernia, or any condition that may be aggravated by intense exercise:	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Contracture:	<input type="checkbox"/> YES	<input type="checkbox"/> NO
If yes, please explain: _____		
Cognitive impairments	<input type="checkbox"/> YES	<input type="checkbox"/> NO
If yes, please explain: _____		
Thermoregulation Issues:	<input type="checkbox"/> YES	<input type="checkbox"/> NO
If yes, please explain your symptoms and preventative measures: _____		
Are you accustomed to vigorous exercise?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Is there any reason not mentioned here why you should not follow		
a regular exercise program?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
If yes, please explain: _____		

Please answer the following questions completely and thoroughly:

List ALL assistive devices you use in everyday life, even if only for short periods (ie., walker, type of wheelchair, AFO, etc.):

Describe your physical abilities. Be as specific as possible:

Upper Extremity (Arms, Hands, and Fingers): _____

Trunk (Back and Abdominals): _____

Lower Extremity (Hips, Legs, Feet, and Toes): _____

Please list ALL other physical challenges or special considerations (ie: limits in ROM, knee instability, joint/muscle disorder, other health issues):

Are you able to sit independently?

YES

NO

If no, describe the type and level of support you need. _____

Are you able to stand independently?

YES

NO

Are you able to take walk independently?

YES

NO

Have you had a recent bone density assessment?

YES

NO

If yes, please attach a copy of the report with the doctor's interpretation.

NOTE: For safety reasons, clients with no bone density assessment or medical report of bone density assessment will be assumed to have osteoporosis. This may place limitations on the exercises used for your exercise program and prescription.

Please list all medications you are currently taking including the type, dosage and its function:

Medication

Dosage mg/day

Type (Function)

Please list your previous rehabilitation (physical therapy, occupational therapy, etc.)

Where

Duration (Months)

Results

List your current fitness/wellness regimen. Include any physical activity you do that would be considered exercise or rehab. (ie. FES bike, Standing Frame):

Type

Duration (Minutes/Hours)

Frequency (How often)

Program Terms

THIRD PARTY BILLING

Clients are responsible for payment until third party coverage begins. Reneu Health will not follow up with these organizations on your behalf.

_____ Initial

INSURANCE COVERAGE

Reneu Health is not a medical facility and does not direct bill insurance companies. Clients will need to submit invoices directly to any third party either for reimbursement or to request payment to Reneu Health.

_____ Initial

NATIONAL TRANSPLANT ASSISTANCE FUND (NTAF)

Clients who have an account with NTAF are responsible for mailing check requests accompanied by the monthly invoice. Please contact NTAF for their policies and procedures: (800) 642-8399.

_____ Initial

AUTHORIZATION FOR AUDIO / VISUAL CONSENT

I hereby consent and authorize the taking of photographs, movies, films, videotapes, tape recordings, or reproductions of the persons who are hereby applying for program participation and consent to use, copyright, license, publication or broadcast of the same for advertising, educational, promotional, or publicity purposes on the part of the Reneu Health and by its affiliated and associated organizations, including its directors, officers, agents, and employees. I hereby grant and assign to Reneu Health the right, title, and irrevocable authority and interest to such Reproductions. I waive any and all claims for compensation and waive any and all claims related to or arising out of the publication and dissemination of the same of any lawful purposes. I further authorize the communication of information concerning the undersigned in connection with the utilization of such Reproductions by Reneu Health and its affiliated or associated organizations, and their respective directors, trustees, officers, agents, servants and employees without claim for compensation and waive all claims related to or arising out of the publication and dissemination of the same.

_____ Initial

CONSENT FOR EMERGENCY TREATMENT

In the event that client should sustain any injuries while participating in activity or while on the premises of Reneu Health the client may be examined and treated by health care personnel, including examination at medical facilities. I voluntarily consent to such examination and treatment for the client, and I release and forever discharge Reneu Health, its directors, officers, staff, employees, contracted employees, agents and volunteers from any actions, suits, damages, claims, or judgments that may result from examination and treatment.

_____ Initial

MISSED SESSIONS

Twenty four hour (24) notice of cancellation is required for missed sessions. Sessions will be forfeited with less than twenty four hour (24) notice. In the instance a cancellation is made, Reneu Health will make every attempt to find the client another suitable time slot to make up for time lost. All cancellations must be made directly with the Director.

_____ Initial

MEDICAL UPDATES

All clients are required to immediately notify Reneu Health of any changes in current medical condition. Such conditions include, but are not limited to clot clots, pressure sores, any skin issues, recent bone fractures and sprains, as well as any change in prescribed medications. Client will indemnify and hold harmless Reneu Health and all employees, volunteers, directors, officers, clients, and agents thereof from any claim, demand and/or cause of action of any nature whatsoever related to any injuries sustained as a result of undisclosed medical conditions or changes in prescribed medications.

_____ Initial

SKIN CONDITION DISCLOSURE

Proactive, preventative skin checks should be done daily. It is the client's responsibility to check his/her skin every day, especially after a training session. It is also the client's responsibility to inform the Reneu Health Director immediately if he/she has any skin irritation or skin breakdown that could potentially become a problem.

It is extremely important the client know his/her responsibility to disclose any skin issues to the Reneu Health Director.

Initial if you have read the above passage and understand it is your responsibility to notify the Reneu Health Director immediately if you notice any skin breakdowns.

_____ Initial

TERMINATION OF SERVICES.

Reneu Health reserves the right to terminate the service relationship with clients at any time, for any reason, with or without cause or notice and with no further liability to client. No oral or written statement shall limit the right to terminate the service relationship.

_____ Initial