PORTSMOUTH REGIONAL HOSPITAL
DIVISION OF REHABILITATION SERVICES
COMMUNITY EXERCISE PROGRAM RELEASE FORM

I, _____, do hereby elect to participate in the Portsmouth Regional Rehabilitation Services' Community Exercise Program. I, for heirs, beneficiaries, executors, and myself hereby acknowledge to and agree with Portsmouth Regional Rehabilitation Services that:

1. My participation is entirely of my own accord, voluntarily, for my own benefit.

2. In my sole discretion, I will determine from time to time (which determination may be, but shall not be required to be, made in consultation with my physician) the extent to which I assume for myself, my heirs, beneficiaries, and executors, all risks that I may suffer, or incur sickness or injury, including death, as a result of exercise, exertion, or otherwise as a result of my participation in the program. And, I, for myself, my heirs, beneficiaries and executors, do hereby release, discharge and agree to hold harmless Portsmouth Regional Rehabilitation Services, it's successors, officers, agents and employees, from any and all claims, demand, actions or causes of action arising on account of any such sickness or injury, including death, which I may suffer or incur as a result of exercise, exertion or otherwise as a result of my participation in the program.

3. Nothing herein shall serve to release or in any way to affect adversely any claim by me, my heirs, beneficiaries, executors, or administrators against any insurance company under any group or individual life insurance, health, or hospitalization insurance, accidental death and dismemberment coverage, major medical coverage or disability insurance.

4. I understand that Portsmouth Regional Rehabilitation Services does not undertake to monitor my participation in the program, however there will be supervision.

Signature of Participant Date _____ Date of Birth

Witness Date

PORTSMOUTH REGIONAL HOSPITAL REHABILITATION SERVICES
COMMUNITY EXERCISE PROGRAM
REGISTRATION FORM/MEDICAL HISTORY SCREEN

REGISTRATION INFORMATION: (please print**)**

LAST NAME:	**FIRST NAME:**
DATE OF BIRTH:	**PRIMARY CARE PHYSICIAN:** (physician not practice)
HOME PHONE:	**REFERRING PHYSICIAN:** (physician not practice)
WORK PHONE:	**THERAPIST:** (if applicable)
EMAIL ADDRESS:	**PAYMENT DATE:**
HOME ADDRESS:	

COMMUNITY EXERCISE PROGRAM: *(please check)*

Ø	**Lebed Method**	Ø	**Zumba Class**	Ø	**Balance Chi**
Ø	**No Bones Class**	Ø	**Vinyasa Yoga**	Ø	**Fit to the Core Class**
Ø	**Core Basics Group**	Ø	**Pink Pilates-6 weeks sign up(433-4015 X86237**	Ø	**"20-20-20" Yoga, Pilates & Cardio Fusion**
Ø	**Coffee Meditation**	Ø		Ø	

MEDICAL HISTORY: (please circle all that apply and comment if appropriate)

			COMMENTS
YES	**NO**	High or low blood pressure?	
YES	**NO**	Heart problems (including murmur, abnormal heart rate etc)?	
YES	**NO**	A pacemaker?	
YES	**NO**	Angina (chest pain)?	
YES	**NO**	A problem with shortness of breath?	
YES	**NO**	Asthma, allergies or sinus problems?	
YES	**NO**	Lung problems (bronchitis, emphysema, pneumonia)?	
YES	**NO**	Kidney or bladder control problems? (urgency, incontinence, retention)	
YES	**NO**	Bowel problems? (constipation, diarrhea, incontinence)	
YES	**NO**	Thyroid problems?	
YES	**NO**	Diabetes or low blood sugar?	
YES	**NO**	Cancer?	
YES	**NO**	Osteoporosis?	
YES	**NO**	A stroke, head injury or concussion?	
YES	**NO**	Any muscular diseases: Multiple sclerosis, polio, cerebral palsy etc.?	
YES	**NO**	Fainting spells, seizures or epilepsy?	
YES	**NO**	A history of fractures, frequent joint sprains or muscle strains?	
YES	**NO**	A history of bursitis or tendinitis?	
YES	**NO**	Arthritis or any unusual joint pain or swelling?	
YES	**NO**	A history of fibromyalgia, fibromyositis, or chronic fatigue syndrome?	
YES	**NO**	A history of neck or back pain?	
YES	**NO**	Do you wear contact lenses or glasses?	
YES	**NO**	Hearing loss?	
YES	**NO**	Problems with loss of balance or falling?	

I believe all information to be true and complete. Signature: _____ Date: _____