CANYON PHYSICAL THERAPY AND AQUATIC REHABILITATION

Welcome to the **CANYON WELLNESS PROGRAM**!

This program is designed to allow you to continue/initiate the pursuit of your health/wellness goals. You may have just completed a course of Physical Therapy or are ready to initiate a personalized fitness routine in a less overwhelming environment than the local gym. There are many reasons to begin an exercise routine and whatever yours may be the CANYON WELLNESS PROGRAM is a comfortable environment that will allow you to perform your independent exercise routine.

We offer a new modern facility with a wide range of strengthening and exercise equipment in our gym, as well as the benefits of a multi-depth salt water exercise pool.

Our hours of operation for the CANYON WELLNESS PROGRAM are **Monday, Wednesday, Friday: 7:00 am – 6:00 pm and Tuesday, Thursday: 8:00 am-7:00 pm**. We ask that wellness clients finish promptly with their routine by the end of the open wellness hours to allow us to carryout business duties for the end of the day.

The CANYON WELLNESS PROGRAM has no initial sign on fee or contracts. We have a monthly fee of $65.00 to be paid at the beginning of each month for that month of service (1-last business day of the month), ½ month $32.50 (1-15 or 16-31) or $7.00 per day.

Once again, our entire staff looks forward to working with you and demonstrating our commitment towards helping you achieve your health and wellness goals!

CANYON WELLNESS PROGRAM

WAIVER & RELEASE FORMS

Because physical exercise can be strenuous and subject to risk of injuries, the staff at CWP urges you to obtain a physical examination from a doctor before using any exercise equipment or participating in any exercise activity. You agree that if you engage in any physical exercise or activity, or use any facility amenity on the premises or off the premises including any sponsored CWP event, you do so entirely at you own risk. You agree that you are voluntarily participating in these activities and use of these facilities and premises and assume all risks of injury, illness, or death. We are also not responsible for any loss of your personal property. This waiver and release of liability includes, without limitations, all injuries which may occur as a result of; (a) your use of all amenities and equipment in the facility and your participation in any activity, class, program, personal training or instruction, (b) the sudden and unforeseen malfunctioning of any equipment (c) our instruction, training, or supervision and (d) your slipping and or falling while in the facility or on the facility premises, including adjacent sidewalks and parking areas.

You acknowledge that you have carefully read this "waiver and release" and fully understand that it is a release of liability. You agree to release and discharge the facility, and all affiliates, employees, agents, representatives, successors, or assigns, from any and all claims or causes of action and you agree to voluntarily give up or waive any right that you may otherwise have to bring legal action against the facility for personal injury or property damage.

To the extent that the statute or case law does not prohibit releases for negligence, this release is also for negligence on the part of the Facility, its agent, and employees.

If any portion of this release form liability shall be deemed by a Court of competent jurisdiction to be invalid, then the remainder of this release form liability shall remain in full force and effect and the offending provision or provisions severed here from.

By signing this release, I acknowledge that I understand its content and that this release cannot be modified orally.

Signed: _____ Dated: _____

Informed consent

By signing this document, I acknowledge that I have voluntarily chosen to participate in a program of progressive physical exercise. I acknowledge being informed of the strenuous nature of the program and the potential for unusual, but possible, physiological results including but not limited to abnormal blood pressure, fainting, heart attack or death. I assume all risk for my health and well-being and hold harmless of any responsibility the instructor, facility or any persons involved with this program and testing procedures. I understand that questions about exercise procedures and recommendations are encouraged and welcomed.

Signed: _____ Dated: _____

Wavier

By signing this document, I acknowledge that I have been informed of the need to obtain a physician's examination and approval prior to beginning this exercise program. I fully understand that the program may be strenuous and choose to participate completely voluntarily. I accept all responsibility for my health and any resultant injury or mishap that may affect my well-being or health in any way. I hold harmless of any responsibility the instructor, facility or any persons involved with this program or testing procedures.

Signed: _____ Dated: _____

ACKNOWLEDGEMENT of DUES LIABILITY

I hereby acknowledge that my membership in the Canyon Wellness Program is monthly and dues are $65.00 per month, or $32.50 for ½ month (1-15 or 16-31) or $7.00 per day and may be terminated any time. I agree to notify CWP in writing or verbally if I decide to stop my participation in the Wellness Program.

Signed: _____ Dated: _____

AQUATIC THERAPY POOL RULES

1. Wellness members must complete registration forms and be notified of acceptance before participating in program.
2. Please sign in at the front desk.
3. Please shower before entering pool.
4. Please do not leave clothing in bathroom stalls.
5. Proper swimming attire is required. Pool shoes are recommended but not required.
6. Please dry off completely before leaving pool room. Wet hallways are slippery and dangerous.
7. Pool attendees must be ambulatory.
8. Pool attendees must be continent of both bowel and bladder.
9. Open wounds must be covered by an occlusive waterproof dressing, such as an OpSite bandage.
10. No one with a communicable disease is allowed in pool.
11. Children under 16 are not allowed in the Wellness program; children 16-18 must be accompanied by an adult to participate in the Wellness program.
12. No diving, running or horseplay is permitted in pool area.
13. No gum, smoking or glass containers are allowed in pool area.
14. All profanity, improper behavior and vulgar remarks are prohibited.

Signed _____ Dated:_____

CANYON WELLNESS PROGRAM

Health History Form

NAME: _____ DATE: _____

ADDRESS: _____ CITY:_____ ZIP:_____

DOB: _____ AGE:_____

PHONE: _____ WORK PHONE: _____

HEALTH REPORT:

EMERGENCY CONTACT: _____ PHONE: _____

DOCTOR'S NAME: _____ PHONE: _____

Regular exercise is associated with many health benefits. Increasing physical activity is safe for most people. However, some individuals should check with a physician before they become more physically active. Completion of this questionnaire is a first step when planning to increase the amount of physical activity in your life. Please read each question carefully and answer every question honestly:

1. Do you or have you ever had any of the following conditions?

CONDITION (circle one)			DESCRIPTION
Heart Attack	yes	no	_____
Stroke	yes	no	_____
Chest Pain	yes	no	_____
Hypertension	yes	no	_____
Diabetes	yes	no	_____
Cancer	yes	no	_____
High Cholesterol	yes	no	_____
Hernia	yes	no	_____
Arthritis	yes	no	_____
Thyroid	yes	no	_____
Anemia	yes	no	_____
Faint, Dizzy or Loss of Balance	yes	no	_____
Pregnant	yes	no	_____
Other	yes	no	_____

Do you know of any other reason you should not exercise or increase your physical activity?

If you answered yes to any of the above conditions, talk with your doctor **before** you become more physically active. Tell your doctor your plan to exercise and to which CONDITIONS you answered yes.

If you honestly answered no to all conditions you can be reasonably certain you can safely increase your level of physical activity gradually.

If your health changes so you then answer yes to any of the above conditions, seek guidance from a physician.

2. Have you ever been injured in any of the following areas?

BODY PART			DESCRIPTION	WHEN
Neck	yes	no	_____	_____
Shoulders	yes	no	_____	_____
Arms	yes	no	_____	_____
Abdomen	yes	no	_____	_____
Back	yes	no	_____	_____
Legs	yes	no	_____	_____

3. Are you currently taking any medication? (Circle One) yes no
Type: _____ Reason: _____
Type: _____ Reason: _____
Type: _____ Reason: _____

4. Are you currently under the care of a physician for any reason at all? (Circle One) Yes No
If yes, explain _____

5. Do you smoke cigarettes? (Circle One) Yes No If yes, how much? _____

6. Do you know of any physical condition that you have that could be aggravated by exercising or exerting yourself? (Circle One) Yes No
If yes, explain _____

7. Are you taking any medication which could cause a reaction while exercising? (Circle One) Yes No
If yes, explain _____

8. Does your doctor know that you are beginning a new exercise program? Yes No

9. If your doctor knows that you are going to begin a new exercise program, does he/she object? Yes No
If yes, explain _____

RELEASE

I know of no physical or mental condition which I, or my doctor, feel could be aggravated by my using the equipment and facilities or, participating in activities sponsored by this facility. I agree to advise the facility management in writing if any of the above changes or if my doctor advises me to stop, reduce or otherwise adjust my exercise regimen at the facility. I will advise management immediately if I injured myself in any way while on the facility property. The information I have given on this form is, to the best of my knowledge, complete and accurate.

Signature: _____Date: _____

CANYON WELLNESS PROGRAM

Medical Clearance Form

Dear Doctor _____

Your patient, _____, Date of Birth _____,

Phone Number _____ wishes to take part in an exercise program and/or fitness assessment. The exercise program may include progressive resistance training, flexibility exercises, and a cardiovascular program; increasing in duration and intensity over time. The fitness assessment may include a sub-maximal cardiovascular fitness test and measurements of body composition, flexibility, and muscular strength and endurance.
By completing this form, you are not assuming any responsibility for our exercise and assessment program. Please identify any recommendations or restrictions for your patient's fitness program below (Physician's Recommendations).

Patient's Consent and Authorization

I consent to and authorize_____ to release to Canyon Wellness Program health information concerning my ability to participate in an exercise program and/or fitness assessment. I understand this consent is revocable except to the extent action has already been taken. Authorization is not valid beyond one year from date of signature. Further disclosure or release of my health information is prohibited without specific written consent of person to whom it pertains.

Member's signature_____date_____

Physician's Recommendations

(**PLEASE SELECT ONE SIGN & FAX BACK**)

___ I am not aware of any contraindications toward participation in a fitness program.

___ I believe the applicant can participate, but urge caution because:

___ The applicant should not engage in the following activities:

___ I recommend the applicant not participate in the above fitness program.

Physician's signature _____ **DATE** _____

Physician's name (print) _____

Address_____ City, State, Zip _____

Phone _____ Fax _____

2852 N NAVAJO DR STE A PRESCOTT VALLEY, AZ 86314 PHONE 928-772-9797 **FAX 928-772-9340**