1 One on One
PHYSICAL THERAPY

PERMISSION FOR PARENT/LEGAL GUARDIAN TO LEAVE SITE DURING ACL SCREENING/OR HAVE THEM DRIVE THEMSELVES

I, _____, acknowledge that I am the _____
(Parent/guardian name) (Relationship to patient)

of _____.
(Patient)

I understand that I may leave the One on One Physical Therapy facility during my child's ACL Screening appointment/or have they may drive themselves to the appointment. I agree to stay within a 10 mile radius of One on One Physical Therapy while I am gone, as well as return to the facility at least 5 minutes prior to the end of my child's scheduled appointment. I further agree to provide a pager or cell phone number where I can be reached during my absence. I understand that my ability to leave the premise can be revoked immediately if I fail to comply with the aforementioned requirements.

Cell number: _____

_____ _____
(Parent/legal guardian signature) (date)

_____ _____
(Witness) (date)

PERMISSION FOR MEDICAL TREATMENT AND TRANSPORT

As the parent/legal guardian of the above patient, I hereby give One on One Physical Therapy permission to call 911 in the event that myself or my child requires advanced medical care. I also grant permission for emergency medical personnel to transport myself or my child to a center of advanced care, if deemed necessary. I further grant permission to any and all physicians, surgeons, and medical personnel to treat myself or my child if advanced treatment is reasonably required. I acknowledge that I am financially responsible for the cost of such medical care in the event that I am not reimbursed by my health insurance provider.

_____ _____
(Parent/legal guardian signature) (date)

_____ _____
(Witness) (date)

Informed Consent and Liability Waiver and Release

ACL Screening is a patient care service. The purpose of this screening is to identify risk factors for injury. All procedures will be thoroughly explained to you before you are asked to perform them. You are expected to fully cooperate with the screening.

By signing below, and based on the above information, you expressly waive, release, and discharge One on One Physical Therapy, Inc. and its officers, directors, employees, agents, affiliates, successors and assigns (which are collectively referred to as "the Released Parties"), from any and all liability, claims, demands. actions and causes of action whatsoever arising out of or related to any loss, damage, or injury, including death, that may be sustained by you, or to any property belonging to you, while participating in physical therapy treatment, or while on or upon the premises where the physical therapy is being conducted. Further, you covenant not to sue or assert any such claims against the Released Parties, and forever release and discharge the Released Parties from liability for such claims.

BY SIGNING THIS DOCUMENT, YOU CONFIRM TO ONE ON ONE PHYSICAL THERAPY, INC., FOR THE BENEFIT OF THE RELEASED PARTIES (AS DEFINED ABOVE), THAT YOU HAVE CAREFULLY READ THIS DOCUMENT AND FULLY UNDERSTAND ITS CONTENTS, VOLUNTARILY AGREE TO EACH OF ITS TERMS AND PROVISIONS, AND SIGN OF YOUR OWN FREE WILL.

Signature of client:_____

Printed name of client:_____

Date:_____

If Under 18 Years of Age:

Signature of Parent or Legal Guardian:_____

Printed Name of Parent or Legal Guardian_____

Relationship to client:_____

MEDICAL HISTORY QUESTIONNAIRE

NAME: _____ **DATE OF BIRTH:** _____
OCCUPATION: _____ **GENDER:** M F
PRIMARY CARE PHYSICIAN: _____
PHYSICIAN TELEPHONE NUMBER: _____

PLEASE INDICATE IF YOU HAVE EXPERIENCED ANY OF THE FOLLOWING CONDITIONS:

Musculoskeletal
__Osteoporosis/Osteopenia
__Arthritis
__Hypothyroid
__Fibromyalgia
__Chronic Fatigue
__Gout in _____
__Bursitis
__Plantar Fasciitis
__Cysts/Lipomas
__TMJ
__Chronic Headaches
__Tendonitis
__Whiplash
__Strains/Sprains
__Chronic Pain in:
  __Neck
  __Mid-back
  __Low back
  __Hip
  __Arm
  __Leg
  __Shoulder
  __Wrist/Hand
__Broken Bones
__Herniated Disc
__Sciatica

Respiratory
__Pneumonia
__Asthma
__Breathing Problems
__Sinusitis
__Shortness of Breath

Digestive
__Ulcers
__Colitis
__IBS
__Crohn's Disease
__Gluten Intolerance
__Constipation
__Diarrhea
__Gallstones
__Gas/Bloating
__Indigestion
__Reflux/Heartburn

Circulatory
__Heart Disease
__Heart Attack
__Stroke
__Chest Pain
__Palpitations
__Mitral Valve Prolapse
__Anemia
__Hemophilia
__High Blood Pressure
__High Cholesterol
__Peripheral Artery Disease
__Raynaud's Disease
__Varicose Veins
__Heart Murmur
__Blood Clots/Phlebitis

Skin Disorders
__Fungal Infections
__Athlete's Foot
__Impetigo
__Eczema/Dermatitis
__Psoriasis
__Easily Irritated Skin

Nervous System
__Dizziness
__ALS
__Multiple Sclerosis
__Parkinson's Disease
__Bell's Palsy
__Neuritis
__Spinal Cord Injury
__Trigeminal Neuralgia
__Seizures/Epilepsy
__Neuropathy

Other
__Diabetes
__Cancer: _____
__Kidney Disease
__Hepatitis
__HIV / AIDS
__Lupus
__Cystitis
__High Stress
__Grieving
__Anxiety/Panic Attacks
__Bipolar Syndrome
__Depression
__PMS
__Menopause Difficulties
__Insomnia
__Allergies: _____
__Other conditions not listed:
_____
_____
_____
_____
_____

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Do you experience any of the following with physical activity and/or exercise?

__Chest Pain
__Joint Pain
__Numbness/Tingling
__Shortness of Breath
__Swelling

Are you Pregnant? YES NO Due Date: _____

Exercise History: _____ times / week __Cardio __Aerobics Classes __Weights

__Yoga __Pilates __Other: _____

Do you drink caffeine? Y / N # of cups/day:_____ Do you smoke? Y/N # packs/day: ____

Are you presently being treated by a doctor? Y/N For what conditions?

_____
_____
_____

Current Medications:

NAME:	FOR WHAT CONDITION?
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____

Do you take vitamins/dietary supplements? YES / NO
List: _____

Are you experiencing any pain at this time? YES / NO
Explain: _____

Why are you stating an exercise program or seeking massage therapy? _____

_____
_____

Please list any other medical conditions, personal goals or concerns you would like to address with our staff: _____

_____
_____
_____

I certify that the above information is accurate. I understand that it is my responsibility to keep my medical record current and to alert the Equipoise staff of any physical/emotional changes as they occur. I understand that fitness trainers, massage therapist and registered dieticians do not diagnose disease or prescribe medications and that they are not a substitute for medical care.

SIGNATURE: _____ DATE: _____

ID: **Date:**

EATING QUESTIONNAIRE

Instructions: The following questions are concerned with the past four weeks (28 days) only. Please read each question carefully. Please answer all of the questions. Please only choose one answer for each question. Thank you.

Questions 1 to 12: Please circle the appropriate number on the right. Remember that the questions only refer to the past four weeks (28 days) only.

	On how many of the past 28 days ……	No days	1-5 days	6-12 days	13-15 days	16-22 days	23-27 days	Every day
1	Have you been deliberately trying to limit the amount of food you eat to influence your shape or weight (whether or not you have succeeded)?	0	1	2	3	4	5	6
2	Have you gone for long periods of time (8 waking hours or more) without eating anything at all in order to influence your shape or weight?	0	1	2	3	4	5	6
3	Have you tried to exclude from your diet any foods that you like in order to influence your shape or weight (whether or not you have succeeded)?	0	1	2	3	4	5	6
4	Have you tried to follow definite rules regarding your eating (for example, a calorie limit) in order to influence your shape or weight (whether or not you have succeeded)?	0	1	2	3	4	5	6
5	Have you had a definite desire to have an empty stomach with the aim of influencing your shape or weight?	0	1	2	3	4	5	6
6	Have you had a definite desire to have a totally flat stomach?	0	1	2	3	4	5	6
7	Has thinking about food, eating or calories made it very difficult to concentrate on things you are interested in (for example, working, following a conversation, or reading)?	0	1	2	3	4	5	6
8	Has thinking about shape or weight made it very difficult to concentrate on things you are interested in (for example, working, following a conversation, or reading)?	0	1	2	3	4	5	6
9	Have you had a definite fear of losing control over eating?	0	1	2	3	4	5	6
10	Have you had a definite fear that you might gain weight?	0	1	2	3	4	5	6
11	Have you felt fat?	0	1	2	3	4	5	6
12	Have you had a strong desire to lose weight?	0	1	2	3	4	5	6

Questions 13-18: Please fill in the appropriate number in the boxes on the right. Remember that the questions only refer to the past four weeks (28 days).

Over the past four weeks (28 days)…….

13	Over the past 28 days, how many times have you eaten what other people would regard as an unusually large amount of food (given the circumstances)?	……..
14	….On how many of these times did you have a sense of having lost control over your eating (at the time that you were eating)?	……..
15	Over the past 28 days, on how many **DAYS** have such episodes of overeating occurred (i.e. you have eaten an unusually large amount of food and have had a sense of loss of control at the time)?	……..
16	Over the past 28 days, how many times have you made yourself sick (vomit) as a means of controlling your shape or weight?	……..
17	Over the past 28 days, how many times have you taken laxatives as a means of controlling your shape or weight?	……..
18	Over the past 28 days, how many times have you exercised in a "driven" or "compulsive" way as a means of controlling your weight, shape or amount of fat or to burn off calories?	……..

Questions 19-21: Please circle the appropriate number. Please note that for these questions the term "binge eating" means eating what others would regard as an unusually large amount of food for the circumstances, accompanied by a sense of having lost control over eating.

19	Over the past 28 days, on how many days have you eaten in secret (ie, furtively)?.....Do not count episodes of binge eating	No days	1-5 days	6-12 days	13-15 days	16-22 days	23-27 days	Every day
		0	1	2	3	4	5	6
20	On what proportion of the times that you have eaten have you felt guilty (felt that you've done wrong) because of its effect on your shape or weight? .....Do not count episodes of binge eating	None of the times	A few of the times	Less than half	Half of the times	More than half	Most of the time	Every time
		0	1	2	3	4	5	6
21	Over the past 28 days, how concerned have you been about other people seeing you eat? .....Do not count episodes of binge eating	Not at all		Slightly	Moderately			Markedly
		0	1	2	3	4	5	6

Questions 22-28: Please circle the appropriate number on the right. Remember that the questions only refer to the past four weeks (28 days)

	On how many of the past 28 days ……	Not at all		Slightly		Moderately		Markedly
22	Has your weight influenced how you think about (judge) yourself as a person?	0	1	2	3	4	5	6
23	Has your shape influenced how you think about (judge) yourself as a person?	0	1	2	3	4	5	6
24	How much would it have upset you if you had been asked to weigh yourself once a week (no more, or less, often) for the next four weeks?	0	1	2	3	4	5	6
25	How dissatisfied have you been with your weight?	0	1	2	3	4	5	6
26	How dissatisfied have you been with your shape?	0	1	2	3	4	5	6
27	How uncomfortable have you felt seeing your body (for example, seeing your shape in the mirror, in a shop window reflection, while undressing or taking a bath or shower)?	0	1	2	3	4	5	6
28	How uncomfortable have you felt about others seeing your shape or figure (for example, in communal changing rooms, when swimming, or wearing tight clothes)?	0	1	2	3	4	5	6

What is your weight at present? (Please give your best estimate). …….

What is your height? (Please give your best estimate). …….

If female: Over the past three-to-four months have you missed any menstrual periods? ……

If so, how many? …….

Have you been taking the "pill"? ……..

THANK YOU

EDE-Q Norms

The following data are from a community-based sample of 241 women (Fairburn & Beglin, 1994).

	Mean	**SD**
Restraint Subscale	1.251	1.323
Eating Concern Subscale	0.624	0.859
Shape Concern Subscale	2.149	1.602
Weight Concern Subscale	1.587	1.369
Global Score (4 Subscales)	1.554	1.213

Assessment of Eating Disorders: Interview or Self-Report Questionnaire? Fairburn, C. G., & Beglin, S. J. (1994). *International Journal of Eating Disorders, 16, 363-370.*

In addition, Mond *et al.* (2006) provide general population norms and percentile ranks for the EDE-Q

Mean (SD) scores on the EDE-Q for young adult women by age group:

Age (yr)	**18–22 (*n*=1186)**	**23–27 (*n*=908)**	**28–32 (*n*=1206)**	**33–37 (*n*=928)**	**38–42 (*n*=1003)**
Restraint	1.29 (1.41)	1.34 (1.39)	1.28 (1.37)	1.27 (1.43)	1.31 (1.38)
Eating Concern	0.87 (1.13)	0.81 (1.10)	0.78 (1.07)	0.69 (1.04)	0.61 (0.94)
Shape Concern	2.29 (1.68)	2.24 (1.61)	2.37 (1.65)	2.10 (1.67)	2.10 (1.60)
Weight Concern	1.89 (1.60)	1.84 (1.50)	1.90 (1.51)	1.64 (1.48)	1.64 (1.41)
Global score	1.59 (1.32)	1.56 (1.26)	1.58 (1.23)	1.42 (1.24)	1.41 (1.15)

Percentile ranks for EDE-Q subscale scores for young adult women (*n*=5,255)

Percentile Rank	Restraint	Eating Concern	Weight Concern	Shape Concern	Global Score
5	—	—	—	—	0.04
10	—	—	—	0.25	0.14
15	—	—	0.20	0.50	0.26
20	—	—	0.40	0.63	0.36
25	—	—	0.40	0.88	0.47
30	0.20	0.20	0.60	1.00	0.60
35	0.40	0.20	0.80	1.25	0.74
40	0.40	0.20	1.00	1.50	0.88
45	0.60	0.20	1.20	1.63	1.04
50	0.80	0.20	1.40	1.88	1.24
55	1.00	0.40	1.80	2.13	1.43
60	1.20	0.40	2.00	2.50	1.61
65	1.60	0.60	2.20	2.75	1.83
70	1.80	0.80	2.60	3.13	2.04
75	2.20	1.00	2.80	3.50	2.29
80	2.60	1.40	3.20	3.88	2.60
85	3.00	1.80	3.60	4.25	2.94
90	3.60	2.40	4.00	4.75	3.36
95	4.00	3.20	4.60	5.25	4.00
99	5.20	4.60	5.60	5.88	4.97

Mond, J. M., Hay, P. J., Rodgers, B., & Owen, C. (2006). Eating Disorder Examination Questionnaire (EDE-Q): Norms for young adult women. *Behaviour Research and Therapy, 44, 53-62.*

Summary: Higher scores indicate greater levels of symptomatology

Fairburn, C.G., & Beglin, S.J. (1994). Assessment of eating disorders: interview or self-report questionnaire? *International Journal of Eating Disorders, 16,* 363-370.

Permission to Photograph/Video

I grant One on One Physical Therapy, its representatives and employees, the right to take

Photographs/videos of me and my property in connection with the above identified subject. I authorize

One on One Physical Therapy, its assigns and transferees to copyright, use and publish the

same in print and/or electronically.

I agree that One on One Physical Therapy may use such photographs/videos of me with or without

my name and for any lawful purpose, including for example such purposes as publicity,

illustration, advertising, social media and web content.

I have read and understand the above:

Signature: _____ Printed Name: _____

Signature of parent or guardian (if 18 or under): _____

Date:_____