



**STRIVING TO MEET YOUR GOALS**

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**Wellness Consent Form**  
 For Exercise at Orthopedic & Sports Physical Therapy Inc.

<i>Please Print</i>	
Patient Name _____ (First, Middle Initial & Last)	Date of Birth ____/____/____
Mailing Address _____ Street	Home Number _____
City _____ State _____ ZIP _____	Work Number _____
Emergency Contact _____ (Name & Relationship)	Phone Number _____

1. Please list any pertinent injuries, strains, pulled muscles, surgeries, etc.:  
 \_\_\_\_\_  
 \_\_\_\_\_
  
2. Please list any medical conditions or other limitations that affect performance/activity/strength, or the ability to exercise or use the exercise equipment, therapeutic pool, or AquaMed bed?  
 \_\_\_\_\_  
 \_\_\_\_\_
  
3. Are you currently being seen in physical therapy?      Yes      No      If yes, Therapist: \_\_\_\_\_
4. Are you currently under the care of a physician?      Yes      No      If yes, Physician: \_\_\_\_\_
5. Please list primary physician if different from question #4. \_\_\_\_\_
6. Was exercise prescribed by your physician?      Yes      No
  - a. If no, do you need a prescription?      Yes      No      Not Sure
7. Are you currently pregnant?      Yes      No

Name:

Date:

I agree to the following: (please initial each line)

1. \_\_\_\_\_ I agree that I understand the use of any exercise equipment and do not have any questions or agree to ask the floor personnel if I have any questions
2. \_\_\_\_\_ I agree that I am comfortable in the water and can enter/exit the pool safely or will ask for assistance if needed.
3. \_\_\_\_\_ I agree that I understand the rules and regulations of the pool/ gym area or agree to ask the floor personnel if I have any questions.
4. \_\_\_\_\_ I understand there are personal training options available if I need further assistance with exercise or equipment and will ask for information.
5. \_\_\_\_\_ I agree that I do not need assistance getting on or off the AquaMed bed and agree to ask if I need assistance.
6. \_\_\_\_\_ I agree that I do not have any concerns regarding the use of Paraffin (heated wax treatment used for arthritis, muscle/ joint pain, and to improve skin integrity) if used and agree to ask if I have concerns at the time of use.
7. \_\_\_\_\_ I agree to inform OSPTI of any changes that may affect my ability to use the exercise equipment, therapeutic pool, AquaMed bed and other equipment/ wellness procedures used.
8. \_\_\_\_\_ I understand that all discussed funds are non-refundable unless I have a physician's order to discontinue.

I consent that I have read the above and have listed any and all necessary information.  
I do not hold OSPTI liable for any unforeseen conditions/incidents.

\*If being seen for the Personal Exercise Program (PEP) or Massage Therapy please read, initial, and sign below. If you believe that in the future you may be seen for either the PEP or Massage please ask about these forms.

Please initial:

1. \_\_\_\_\_ If being seen for Massage therapy please initial that you have received the Client Bill of Rights.
2. \_\_\_\_\_ If being seen for the Personal Exercise Program please initial that you have received the HIPAA.

\_\_\_\_\_  
Signature of Participant and/or Guardian

\_\_\_\_\_  
Date

Thank you & we hope you enjoy your workouts.  
Please advise us of any suggestions or questions that you may have.

OSPTI Staff

*Office Use Only:*

One time drop-in Water Aerobic fee used:      Yes      Date: \_\_\_\_/\_\_\_\_/\_\_\_\_