JUST BE FIT, INC.

PHYSICAL THERAPY • EXERCISE BASED REHABILITATION • PERSONAL TRAINING

Welcome!

On behalf of your Kinesiotherapist and all of the staff at Just Be Fit, Inc., we would like to welcome you to our facility. No other pain relief and rehabilitation center equals the certification, training and expertise you'll discover at Just Be Fit, Inc. Our multidisciplinary care team makes us the complete source for effective pain relief and lasting results.

Your specific specialized program is called "Exercise Based Rehabilitation" and was created for any age individual with re-occurring pain or injuries who is looking to improve their quality of life. Our approach emphasizes the concept of functional exercise to help you improve your level of function, strength, flexibility, endurance or balance. Our expert staff of registered Kinesiotherapists helps make the transition from Physical Therapy to Exercise Based Rehabilitation painless and effective. Our motto is: ***Improvement through movement.***

Our expert approach to Exercised Based Rehabilitation involves:

- Restoring mobility, stability and function based upon your specific injury.
- Joint mobilization techniques to increase range of motion.
- Hands-on soft tissue therapy to decrease pain and neurological symptoms.
- Creation of proper postural alignment and movement patterns that have long lasting results.

Our Kinesiotherapists treat:

- **Neck issues**: Cervical Herniated disc, Arthritis, Mechanical Neck Pain
- **Back issues:** Stenosis, Sprains/Strains, Sciatica¸ Herniated Discs, Arthritis
- **Hip issues:** Bursitis, Piriformis Syndrome, Sacroiliac Joint Dysfunction
- **Knee issues:** Arthritis, Iliotibial Band Syndrome, Knee Bursitis, Ligament Sprains, Meniscal Injuries, Tendonitis
- **Lower Leg** / **Ankle** / **Foot issues:** Gait Disorders, Achilles' Tendonosis, Ankle Sprains, Plantar Fasciitis, Shin Splints

•• **Outpatient Neuro Rehab** - For patients who suffer from problems with:
• Weakness • Balance • Posture • Walking • Coordination • Drop Foot Syndrome

In conjunction with Exercised Based Rehabilitation, we also offer these additional specialized programs:

One-On-One Personal Training - For individuals looking for more expertise and guidance with their exercise program. Whether you want to lose weight, lose inches, get stronger, increase your metabolism, improve your nutrition, or just improve your overall health and fitness our expert team is committed to providing the right "game plan" for you to reach your goals.

Physical Therapy- We provide comprehensive physical therapy services to treat our patients at every stage of rehabilitation, from preventative care to acute and chronic injuries. (covered by most insurance companies)

We have provided professional rehabilitation services at this location since 1999. If you have any questions or concerns please feel free to contact our office at **847-444-1348.**

Please feel free to visit our web site at **www.justbefitinc.com**

Once again thank you for choosing Just Be Fit, Inc.

Living Life Independently Whole Body Approach To Therapy = Success Living Life To Its Fullest Potential

Exercise Based Rehabilitation

HEALTH HISTORY / LIFESTYLE QUESTIONNAIRE

NAME: ____ DATE: _______________
ADDRESS: ______________________________ CITY: _____________ ZIP ____
PHONE (HOME): ( )_____________________ CELL: ( )_________________
PHONE (BUSINESS): ( )____________________ FAX: ( )________________
E-MAIL ADDRESS: __________________________OCCUPATION:____________
AGE:_____ BIRTH DATE:_____/_____/_______ HEIGHT:______ WEIGHT_________
MARRIED _____________ SINGLE ____________
Referred By:____

Do you have children? ( ) YES ( ) NO / If so, how many? ____ Ages ______________

In Case of Emergency, Contact:___________________ Relationship: _______________
Home Phone: ( )__________________ Phone (Cell): ( )______________________
Work ( ) __________________________

Do you currently have a physician? ( ) YES ( ) NO
I) Physician's Name: ___________________________ Phone: ( )______________
Address: ____
II) Physician's Name: ___________________________ Phone: ( )______________
Address: ____

Insurance Information:
PRIMARY
INSURANCE:________________________ADDRESS:______________________________
CITY/STATE/ZIP:_____________________TELEPHONE:____________________________
INSURED ID #:______________________GROUP#:_________________________________
POLICY OWNER NAME: ___________________________DOB:______________________
RELATIONSHIP:__________POLICY OWNER SOCIAL SECURITY #:__________________

MEDICAL HISTORY

Have you ever had, or do you currently have, any of the following:

( ) Alcohol Abuse Problems
( ) Anemia
( ) Aneurism
( ) Asthma
( ) Bronchitis
( ) Chronic Obstructive Pulmonary Disease
( ) Cerebral Palsy
( ) Coronary Artery Disease/Heart Disease
( ) Diabetes Type I, Type II
( ) Emphysema
( ) Fibromyalgia
( ) Gout
( ) Hearing Loss
( ) Hemorrhoids
( ) High Blood Pressure / Hypertension
( ) High Triglycerides
( ) Hypoglycemia
( ) Allergies
( ) Arthritis (Osteo/Rheumatoid/AS)
( ) Angina
( ) Back/Spinal Injury
( ) Cancer
( ) Cerebral Vascular Accident/Stroke
( ) Coronary Vascular Disease
( ) Circulatory Problems
( ) Embolism
( ) Epilepsy
( ) Gastrointestinal/Stomach Problems
( ) Head Injury
( ) Heart Attack
( ) Hernia
( ) High Cholesterol
( ) Hyperglycemia
( ) Crohn's Disease

( )	Kidney Disease	( )	Joint Problems (Knee/Shoulder/Hip/Back)
( )	Lung Disease	( )	Low Blood Pressure
( )	Muscular Dystrophy	( )	Multiple Sclerosis
( )	Osteoporosis	( )	Nervous/Emotional Tension
( )	Paralysis	( )	Parkinson's Disease
( )	Spina Bifida	( )	Poliomyelitis
( )	TMJ	( )	Spinal Cord Injury
( )	Tumors	( )	Thyroid Problems
( )	Varicose Veins	( )	Other ___________________________

MEDICAL HISTORY continued

Please comment here on any marked answers from above:

____

____

Have you recently experienced:

( ) Back/leg Pain____

( ) Blurred or double vision ____

( ) Bowel/Bladder changes ____

( ) Brain Fog____

( ) Calf pain with exercise____

( ) Change in speech pattern____

( ) Chest pain or pressure____

( ) Constant pain unrelieved by rest or movement___________________________

( ) Difficulty keeping balance____

( ) Difficulty sleeping____

( ) Difficulty swallowing____

( ) Dizziness, fainting, or blackouts______________________________________

( ) Falls____

( ) Fatigue____

( ) Irregular heart beat____

( ) Headaches/migraines____

( ) Muscular pain at rest____

( ) Muscular pain with exertion____

( ) Numbness or tingling in arms, hands or legs____________________________

( ) Recurrent cough____

( ) Ringing in ears____

( ) Shortness of breath____

( ) Swollen ankles or legs____

( ) Swollen, stiff, or painful joints_______________________________________

( ) Tremors____

( ) Unexplained weight gain____

( ) Unexplained weight loss____

( ) Unusual skin coloration____

( ) Unusual weakness or fatigue____

( ) A wound that does not heal____

( ) Other____

INJURIES

Have you ever had, or do you have, injuries to any of the following:

( ) ankle, foot	( ) arm, elbow	( ) back	( ) clavicle	( ) Hip
( ) face	( ) knee, thigh	( ) shoulder	( ) wrist/hand	

Please comment here on any marked answer from above:

____
____
____
____

- -

INTERVIEW:

What is your chief complaint:____
____
____
____

How did it start? Injury? When did it happen?______________________________________
____
____
____

If not an injury, how did it start?____
____
____
____

What is the level of your pain on a scale of 0-10?

____

What are your limitations?____
____
____

In what activities is the pain (or other disability) manifested?_______________________
____
____
____

What was your activity level before the injury? Describe:___________________________
____
____

What are your goals regarding therapy?

____
____
____

TREATMENT/SURGERIES

1. Have you undergone a complete medical exam within the last year? ( )YES ( ) NO

2. Please list all medications you are taking:

Name Reason Amount Frequency Side Effects

___

___

___

___

3. Please list any homeopathic, herbal, vitamin, and/or mineral products that you are currently taking for the treatment of any condition or deficiency:

Name Reason Amount Frequency Side Effects

___

___

___

___

4. Please describe any surgery and/or hospitalizations:

Procedure Reasons Date

___

___

___

5. Please list all current diagnostic test (location & date):
   X-Rays: ___
   MRI:___
   CAT Scan:___
   ECG:___
   Stress Test:___

6. Identify any assistive devices you are currently using (cane, brace, etc.), whether the device was prescribed by a physician, and the reason for the device:

___

___

7. Please identify any past or ongoing treatments by a physician, physical therapist, chiropractor, massage therapist, acupuncturist, etc:

   ___

   ___

   ___

8. Has your physician ever advised you against exercise? ( ) YES ( ) NO
   If YES, why?___

WOMEN'S HEALTH

1. Are you pregnant? ( ) YES ( ) NO
2. When was your last menstrual cycle? ___
3. Are you currently ( ) premenopausal ( ) postmenopausal ( ) menopausal
4. List any symptoms that accompany your menstrual cycle:___

___

CARDIOVASCULAR HISTORY

1. Has your physician ever said you have heart or cardiovascular disease?
   ( ) YES ( ) NO

2. Have you ever had Rheumatic Fever? ( ) YES ( ) NO

3. Have you ever had any diagnosed heart problems (murmur, valve defect)?
   ( ) YES ( ) NO

4. Have you ever experienced abnormal chest pain? ( ) YES ( ) NO

5. Do you have unusual shortness of breath, history of dizziness, or fainting?
   ( ) YES ( ) NO

6. Have you ever been diagnosed as having high blood pressure? ( ) YES ( ) NO
   If yes, what value?________/________

7. Have you recently had your blood lipids / cholesterol screened? ( ) YES ( ) NO
   If yes, what were the values?____________________

8. Are you medicated for any of the situations listed above? ( ) YES ( ) NO

FAMILY MEDICAL HISTORY

Have your parents, grandparents, or siblings had any of the following (indicate who):

( )	Anemia	( )	Asthma	( )	Arthritis
( )	Back/Leg Pain	( )	Cardio/heart disease	( )	Congenital Heart disease
( )	Cancer	( )	Diabetes	( )	Epilepsy
( )	Fatigue/lack of energy	( )	Feet/ankle swelling	( )	Heart operations
( )	High cholesterol	( )	High blood pressure	( )	Heart attack 50 or under
( )	Kidney disease	( )	Lung disease	( )	Heart attack over age 50
( )	Migraines	( )	Phlebitis	( )	Recurrent cough
( )	Stroke	( )	Trouble sleeping	( )	Thyroid problems
( )	Stomach/gastrointestinal problems	( )	Other		

Comments:
____
____

I, the undersigned, state that I have answered this questionnaire to the best of my knowledge.

____ ______________________
Signature Date

THANK YOU FOR TAKING YOUR TIME TO PROVIDE THIS NEEDED INFORMATION.

(For Office Use Only)
Is a medical clearance form needed? ( ) YES ( ) NO

INFORMED CONSENT/RELEASE FOR PARTICIPATION IN A EXERCISE BASED REHABILITATION PROGRAM

By my signature, which appears below, I hereby grant my permission for and request that I be evaluated, and treated by the therapist(s) according to the plan of care developed by the therapist and prescribed by my physician in consultation with the therapist(s).

I consent to voluntarily engage in a Exercise Based Rehabilitation program. I acknowledge it has been recommended to me by my therapist that a physician of my choice examine me and obtain his/her approval for my participation in a program within 30 days of the date set forth below. Furthermore, within the 12 month period proceeding the date of this release, I have not been advised by a physician or other health care professional of any medical condition which would prevent me from participating safely in a exercised based rehabilitation program.

If I am taking prescribed medications, I have informed my therapist and further agree to so inform my therapist promptly of any changes, which my doctor or I have made with regard to use of any medications, or change in medical status. I have been informed that during my participation of the therapy session, I will be asked to complete the physical activities unless symptoms such as fatigue, shortness of breath, chest discomfort or pain occur. At that point, I have been advised that it is my complete right to decrease or stop exercise and that it is my obligation to inform the therapist of my symptoms. I hereby state that I have been advised and agree to inform the therapist of my symptoms should any develop.

I understand that during the performance of the program, physical touching and positioning of my body by the therapist may be necessary to assess my muscular and bodily reactions to specific exercises, as well as ensure that I am using proper technique and body alignment. I expressly consent to the physical contact for that stated reasons above.

I understand that the purpose of this program is to enhance my recovery from an illness, injury or surgery. It has been explained to me that there exists the likelihood of changes in the treatment program as my condition changes and I hereby grant my permission for all modifications and changes to the treatment program deemed necessary by the therapist(s).

The procedures and or modalities to be used have been explained to me and I have had the opportunity to ask any questions I had, and acknowledge that I have received answers that are satisfactory to me. I understand that the success of this, or any other medical treatment program depends on my involvement and cooperation with the program including regular attendance at all treatment sessions and conscientious follow through with any home exercises or procedures which may be prescribed by the therapist(s). I understand what is expected of me as a patient and agree to cooperate to the best of my ability.

I hereby attest that I have read and agreed to all statements made above and that my participation in this exercised based rehabilitation program is fully voluntary.

____
Patient Signature

____
Print Name

________/__________/________
Date
* If patient is under 18 years of age, signature of parent or legal guardian is required.

PATIENT MEDICAL INFORMATION RELEASE

SIGNED____**DATE**______________

Dear____ Date________________

Fax #____

Thank you for taking your time to fill out the following brief medical clearance for your patient____.

To design and implement an exercise program for your patient please indicate any recommendations or limitations your patient may have to appropriately begin a safe and effective exercise routine.

____

____

____

____

____

Please list any medications your patient is taking and the heart rate effect.

____

____

____

Please include Blood Pressure_____________________ CHOL______________________

____________________________________ has my approval to begin an exercise program with Just Be Fit with the recommendations and/or limitations stated above.

Signed____ Date_________________________

Thank you for your time!

Please return medical clearance form to:

JUST BE FIT, INC.
420 Lake Cook Road, Suite 101.
Deerfield, IL 60015
Office (847) 444-1348 or Fax (847) 444-1349
www.justbefitinc.com

BILLING AGREEMENT

Sessions will be made by appointment at your convenience and the availability of the fitness specialist. Sessions are based on a 60-minute hour. Sessions will take place at Just Be Fit, Inc. (420 Lake Cook Road Deerfield, IL 60015). As a professional courtesy, cancellations must be made at least 24 hours before the scheduled appointment. Rehab sessions canceled inside of 24 hours of the scheduled appointment will be billed at the normal rate of a single session to the client, or clients.

Insurance Reimbursement
* Patients must have their Doctor fill out appropriate Just Be Fit Referral Form, and obtain a Doctors script explaining exact treatment and diagnosis.
* Each patient has to pre pay for a specific rehabilitation package.
* When sessions are completed from specific package, patient will be given copies of services rendered, and an invoice with treatment dates included ICD-9 diagnosis code(s) and treatment codes.
* Patients are responsible for submitting their own insurance claims.

A refund will be given only with the written consent of Just Be Fit, Inc. under the following circumstances:

1. A patient relocates to another city or location out side the counties of Cook, Lake or Du Page Illinois.
2. The Medical condition a patient suffers from makes it impossible to continue with their fitness specialist. In this case, a physician's written notification is required.

Sessions which remain unused for a period of one (1) year after the date of purchase will not be honored.

I, ______________________, have read, understand and accept these policies as they are related to rehabilitation training procedures with my trainer.

Acknowledged and Agreed,

Client Date

Witnessed,

Therapist Date

Rehabilitation Programs

# OF SESSIONS	PRICE PER SESSION	TOTAL COST
1	**$95.00**	**$95.00**
5	**$90.00**	**$450.00**
10	**$85.00**	**$850.00**
20	**$80.00**	**$1600.00**