

Premier Sports Lab

DEMOGRAPHICS

Name: _____ Date of Birth: _____ Age: _____ ☐ M ☐ F

Home/Cell Phone: _____ Email: _____

Address: _____

City: _____ State: _____ Zip Code: _____

SERVICES YOU ARE INTERESTED IN

- ☐ SPORTS RECOVERY SYSTEMS ☐ SPORTS ENHANCEMENT TRAINING
☐ POST REHAB OPTIMIZATION

CONSENT FOR TREATMENT

I voluntarily consent to allow the providers at Premier Physical Therapy & Associates Inc. to perform the physical evaluation and or assessment of my affected area(s).

Premier Sports Lab will be performed by a licensed Physical Therapist and include a physical evaluation for ROM, strength and special tests to determine possible pathology. Advice and recommendations provided are not to be considered in lieu of medical advice provided by a physician. If symptoms persist a full medical evaluation should be completed by your medical provider.

I fully understand and acknowledge that no guarantees, either expressed or implied, have been made to me regarding the outcome of any recommended medical treatments, procedures and or advice.

I hereby release and discharge Premier Sports Lab, their officers, agents, staff, and representatives from any and all claims, or causes of action whatsoever that may arise from this injury screening, evaluation, assessment or treatment.

I have read this form and understand the procedures that will be performed.

☐ I consent to participate in the Premier Sports Lab program.

Participant / Guardian Signature

Date

OXNARD
1160 NORTH VENTURA RD
OXNARD CA 93030



MOORPARK
6591 COLLINS DR SUITE E8
MOORPARK CA 93021

Name: _____ D.O.B. _____ Date: _____

Date of injury: _____ No current injury ☐ Please skip Section 1 and continue to Section 2.

Services you are interested in:



SPORTS RECOVERY SYSTEMS



SPORTS ENHANCEMENT TRAINING



POST REHAB OPTIMIZATION

Section 1

Please briefly describe the history of your present condition/mechanism of injury:

Please rate the severity of your pain/symptoms by circling the appropriate number on a scale of 0 to 10 with 0 being no pain/symptoms and 10 being severe pain/symptoms.

Pain at worst: 0 1 2 3 4 5 6 7 8 9 10

Pain currently: 0 1 2 3 4 5 6 7 8 9 10

Pain at best: 0 1 2 3 4 5 6 7 8 9 10

Please list any prior Serious Injuries, Falls or Surgeries you have sustained and their approximate date(s):

1. _____
2. _____
3. _____
4. _____

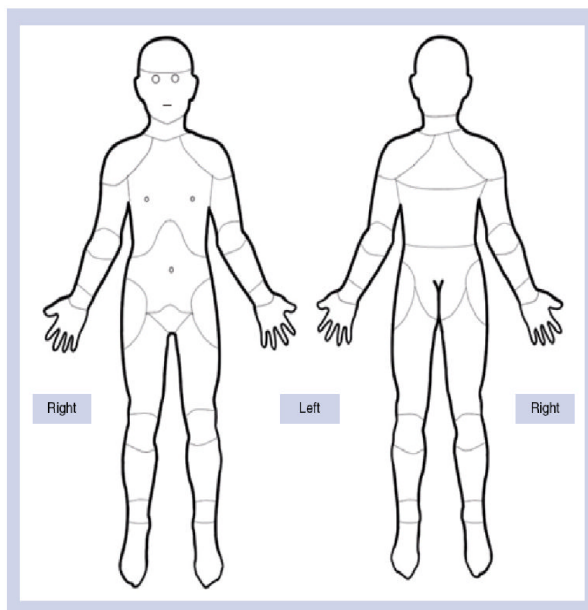
Please list any recent tests and results you have had (X-ray, MRI, CT-Scan, Nerve Conduction):

1. _____
2. _____
3. _____
4. _____

How would you describe your symptoms (circle all that apply):

Aching Burning Shooting Sharp Numbness Tingling
Throbbing Spasms Tightness Dull Constant
Worse in the morning Worse midday Worse at night

**Please circle where your pain / injury is located



Section 2

Please list all medications you are currently taking, including any herbal medication, vitamins or supplements.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Please check ALL illnesses or conditions which apply to you:

- | | |
|---|---|
| <input type="checkbox"/> Alzheimer's/Dementia | <input type="checkbox"/> Epilepsy/Seizures |
| <input type="checkbox"/> Osteoporosis/ Osteopenia | <input type="checkbox"/> Chronic Fatigue Syndrome |
| <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Traumatic Brain Injury |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Cerebral Vascular Accident | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Parkinson's Disease | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Lupus | <input type="checkbox"/> Cancer _____ |
| <input type="checkbox"/> Fracture or Suspected Fracture | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Immunosuppression |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Osteo/Rheumatoid Arthritis | <input type="checkbox"/> Chronic Pain Syndrome |
| <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Other: _____ |

I certify that the information listed above is true and accurate to the best of my knowledge.

Parent of Participant / Participant Signature: _____



Informed Consent Agreement

Premier Sports Lab would like to remind you physical exercise can be strenuous and can be subject to risk of serious injury. With this in mind PSL urges you to obtain a physical examination from a doctor before using any exercise equipment or when participating in any exercise activity. As a member, guest, or participant, you agree that engaging in any physical exercise or activity or use of any PSL amenity on the premises or off the premises, you do so entirely at your 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 limitation, all injuries which may occur, regardless of negligence, as a result of; (a) your use of all PSL 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, supervision (d) your slipping and/or falling while in the facility, or on PSL premises, including adjacent sidewalks and parking areas.

You are acknowledging that you have carefully read this waiver and release, and fully understand that it is a release of liability. You expressly agree to release Premier Sports Lab, their officers, agents, staff, and representatives from any and all claims, or causes of action whatsoever that may arise from this injury screening, evaluation, assessment or treatment. You agree to voluntarily waive any right you may otherwise have to bring a legal action against Premier Sports Lab for negligence, personal injury or property damage.

Please note: Should any part of this agreement be found by a court of law to be against public policy or in violation of any state statute or case precedence, then the remainder of this document will remain in full force.

Participant / Guardian Signature _____

Printed Name _____

Date ____/____/____

Premier Sports Lab Authorized Staff

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Oxnard, CA 93030
P: 805-604-9300

6591 Collins Drive Suite E-8
Moorpark, CA 93021
P: 805-517-0151