



THE ARC OF SAN DIEGO

OUR PLACE WELLNESS CENTER

REGISTRATION FORMS

Before you participate in the Our Place Wellness Center, these forms must be filled out completely. Completing these forms is essential to enable Our Place staff to provide accurate care and a positive experience. Once completed, please return the forms to Our Place staff via email or mail at 3030 Market St. San Diego, CA 92102. If you have questions, please contact Justin Umpierre (jumpierre@arc-sd.com) at 619-685-1175, ext. 246.

Participant Name: _____ Nickname: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Primary Phone: _____ Other Phone: _____

Email Address: _____

Date of Birth: _____ Age: _____ Gender: _____ HT: _____ WT: _____

Name of Parent/Guardian (if applicable): _____ Relationship: _____

Phone: _____ Email: _____

24 HR Emergency Contact: _____ Relationship: _____

Primary Phone: _____ Other Phone: _____

*Alternate Responsible Party: _____ Phone: _____ Relationship: _____

*NOTE: This must be a person who **WILL ACCEPT** responsibility for you/your participant in case of an emergency where you or your emergency contact cannot be contacted. If parents, care-provider, or other person will be out of town while this person is in program, please **attach information** about where/when they can be contacted.

Name of individual filling out this form: _____ Date: _____

Primary Phone: _____ Email: _____

DISABILITY AND MEDICAL INFORMATION

Disability/Diagnosis (please be specific and list all that may affect participation): _____

If disability was caused by injury/accident please specify date: _____

Medical Insurance: _____ Policy #: _____

Primary Doctor: _____ Phone: _____

Office Use Only – Date Received: _____

HEALTH INFORMATION

Please place a "check" in the appropriate box. Please answer the following questions completely.

<u>PARTICIPANT...</u>	<u>YES</u>	<u>NO</u>	<u>COMMENTS OR ASSISTANCE NEEDED</u>
takes medication:	<input type="checkbox"/>	<input type="checkbox"/>	If YES, please fill out separate Medication Schedule Form attached.
has arthritis:	<input type="checkbox"/>	<input type="checkbox"/>	Describe: _____
has history of seizures:	<input type="checkbox"/>	<input type="checkbox"/>	If YES, type: _____ Frequency: _____ Date of last seizure: _____ Usual length: _____ Describe warning signs: _____ Describe how seizures are controlled: _____
has allergies:	<input type="checkbox"/>	<input type="checkbox"/>	Describe type, signs, and treatment: _____ _____
has asthma:	<input type="checkbox"/>	<input type="checkbox"/>	Describe medications used/frequency: _____
is diabetic:	<input type="checkbox"/>	<input type="checkbox"/>	Describe how it's controlled: _____
has high blood pressure:	<input type="checkbox"/>	<input type="checkbox"/>	Describe how it's controlled: _____
has a joint replacement.:	<input type="checkbox"/>	<input type="checkbox"/>	Describe: _____
had surgery within past year:	<input type="checkbox"/>	<input type="checkbox"/>	Describe: _____
had serious injury in past year:	<input type="checkbox"/>	<input type="checkbox"/>	Describe: _____
has diet restrictions:	<input type="checkbox"/>	<input type="checkbox"/>	Describe (attach copy of diet if necessary): _____
is visually impaired:	<input type="checkbox"/>	<input type="checkbox"/>	Describe: _____
is hearing impaired:	<input type="checkbox"/>	<input type="checkbox"/>	Describe: _____
is verbally impaired:	<input type="checkbox"/>	<input type="checkbox"/>	If YES, mark all that apply: <input type="checkbox"/> Hard to Understand <input type="checkbox"/> Sign Language <input type="checkbox"/> Uses Visual Aides/Pictures <input type="checkbox"/> Non-verbal <input type="checkbox"/> Other _____
has heart condition:	<input type="checkbox"/>	<input type="checkbox"/>	Describe: _____
smokes:	<input type="checkbox"/>	<input type="checkbox"/>	Frequency: _____
drinks alcohol:	<input type="checkbox"/>	<input type="checkbox"/>	Frequency: _____

Other health information we should be aware of: _____

MOBILITY INFORMATION

Please place a "check" in the appropriate box. Please answer the following questions completely.

<u>PARTICIPANT...</u>	<u>YES</u>	<u>NO</u>	<u>COMMENTS OR ASSISTANCE NEEDED</u>
uses device for mobility:	<input type="checkbox"/>	<input type="checkbox"/>	If YES, mark all that apply: <input type="checkbox"/> Manual wheelchair <input type="checkbox"/> Walker <input type="checkbox"/> At all times <input type="checkbox"/> Other _____ <input type="checkbox"/> Power wheelchair <input type="checkbox"/> Cane <input type="checkbox"/> For long distances
			If YES, can he/she transfer independently? <input type="checkbox"/> Yes <input type="checkbox"/> No
has prosthetic:	<input type="checkbox"/>	<input type="checkbox"/>	Describe: _____
tires easily:	<input type="checkbox"/>	<input type="checkbox"/>	Describe: _____
walks slowly:	<input type="checkbox"/>	<input type="checkbox"/>	Describe: _____
is inactive:	<input type="checkbox"/>	<input type="checkbox"/>	Describe: _____
has chronic pain:	<input type="checkbox"/>	<input type="checkbox"/>	Describe: _____
has chronic stiffness:	<input type="checkbox"/>	<input type="checkbox"/>	Describe: _____
has difficulty stretching:	<input type="checkbox"/>	<input type="checkbox"/>	Describe: _____
Describe strength and use of upper and lower extremities as it pertains to function, mobility, and range of motion:			

EXERCISE EXPERIENCE

What is your exercise experience level?
 Beginner Intermediate Advanced

How frequently do you exercise?
 Sporadic (1 – 2 times a month)
 Semi-regularly (1 – 2 times a week)
 Frequently (3 – 4 times a week)
 Other _____

What sports or fitness activities have you participated in (list year)? _____

What sports or fitness activities are you interested in? _____

Other mobility and exercise information we should be aware of: _____

BEHAVIORAL INFORMATION

To be completed by participant's primary caregiver or direct service professional.

Please fill out the next section completely and attach existing "Behavior Plan" if applicable.

List any unpredictable or inappropriate negative behaviors: (Example: aggression, property destruction, yelling, etc.)

What causes these behaviors? (Example: fear, frustration, manipulation, hunger, stress, etc.) _____

Are there any triggers we should be aware of? _____

How are negative behaviors handled at home/school/work/program? _____

Does participant have a "PRN" medication for behaviors? YES NO Medication used: _____

Does participant "wander off" or "run-away"? _____

If YES, where are they likely to go? _____

What are triggers/causes? _____

Self-injurious behaviors we should be aware of? _____

If YES, how are these behaviors handled? _____

Other behavioral information we should be aware of: _____

WELLNESS GOALS

Please place a “check” in the appropriate box. Please answer the following questions completely.

What are your barriers to exercise? (check all that apply)

- | | | |
|---|--|---|
| <input type="checkbox"/> Gym membership is too expensive. | <input type="checkbox"/> No gym near my house. | <input type="checkbox"/> It's hard to exercise. |
| <input type="checkbox"/> I don't know how to exercise. | <input type="checkbox"/> I'm afraid to get hurt. | <input type="checkbox"/> I don't have time. |
| <input type="checkbox"/> Other: _____ | | |

Why do you want to exercise? (check all that apply)

- | | | |
|---|---|---|
| <input type="checkbox"/> I want to learn how to exercise. | <input type="checkbox"/> I want to get stronger. | <input type="checkbox"/> I want to lose weight. |
| <input type="checkbox"/> I want to lower my blood pressure. | <input type="checkbox"/> I want to be healthier. | <input type="checkbox"/> I want to reduce pain. |
| <input type="checkbox"/> I want to lower my cholesterol. | <input type="checkbox"/> I want to feel better. | <input type="checkbox"/> I want to reduce stress. |
| <input type="checkbox"/> I want to increase my range of motion. | <input type="checkbox"/> I want to lose body fat. | <input type="checkbox"/> I want to meet new people. |
| <input type="checkbox"/> Other: _____ | | |

When are you available to exercise?

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
<i>(i.e. 8am – 10am)</i>			<i>(i.e. 6pm – 8pm)</i>		<i>(i.e. 9am – 11am)</i>	

What are your wellness goals? _____

How do you expect the Our Place Wellness Center to help you meet your wellness goals? _____

What are you most interested in getting out of your participation in the Our Place Wellness Center? _____

NUTRITIONAL PREPARATION, CLOTHING GUIDELINES, AND PROGRAM RULES

Please "check" each section to acknowledge you have read, understand, and consent.

Nutritional Preparation:

- Ensure you are well nourished on the day of training.
- Where possible, consume a high carbohydrate diet in the 24 hours prior to the training sessions (such as pasta, potatoes, fruit, etc.) if this fits in your nutritional plan. If you have questions, please consult with your doctor.
- You are strongly advised to have eaten some food in the four hours preceding training.
- Ensure you are fully hydrated, particularly in hot conditions. Drink regularly in the days leading up to training, particularly in the 12 hours prior to training.
- Drink water regularly throughout your workout session. Continue to consume adequate fluids following exercise to replace any fluids lost during training.

Clothing Guidelines:

- It is recommended that you wear clean shorts or track pants, a cotton t-shirt or athletic/sports top, socks and non-slip athletic footwear with laces securely fastened.
- No jeans or open toed shoes (i.e. sandals) can be worn to exercise.
- Remove all restrictive jewelry, watches, bracelets or hanging earrings that may get caught in the equipment.
- Bring a bottle of water and a small towel.

Our Place Wellness Program Rules:

- Be kind and courteous to your fellow workout partners at all times.
- Drink water regularly throughout your workout session.
- Eat at least 4 hours before exercising.
- Wear clean workout clothes (no sandals or jeans).
- Wipe down machines with disinfectant wipes after every use.
- Do not answer/use cell phones in the facility.
- Be patient and wait for your turn to use a machine.
- If you are in pain, stop exercising and notify a staff member.
- Wash or sanitize your hands before and after you exercise.
- Shower and apply deodorant prior to exercising.
- If you need help, ask staff for assistance.
- Have fun!

I, the undersigned person, voluntarily sign this agreement, acknowledging I have read and understand the above information. My signature below also confirms that if I failed to understand anything in this document, I have sought and received explanation of its meaning and significance to my complete satisfaction.

Participant's Signature: _____ Date: _____

Participants Printed Name: _____

Conservator's Signature: _____ Date: _____

Conservator's Printed Name: _____

Care Provider Information

To be completed by the consumer's care provider or parent/guardian.

What are the biggest barriers to your child/consumer participating in a wellness program?

What impact do you hope the Our Place Wellness Program will leave on your child/consumer?

How can the Our Place Wellness Program best serve the needs of your child/consumer?

How do you plan on spending your time when your child/consumer is accessing Our Place Wellness Center activities? (check all that apply)

- Utilize the computer lab (i.e. check email, etc.).
- Hang out at Our Place Café (i.e. eat lunch, read a book, relax, etc.).
- Connect with other care providers/parents.
- Observe and/or provide support to your child/consumer in each activity.
- Speak with certified program consultants regarding your child/consumer's needs.
- I do not plan on being at the Our Place Wellness Center during operating hours.

Agreement of Release & Waiver of Liability

I, _____, hereby agree to the following:

1. That I am participating in the Our Place Wellness Center during which I will receive information and instruction about exercise and health. I recognize that the Our Place Wellness Center's classes require physical exertion that may be strenuous and may cause physical injury, and I am fully aware of the risks and hazards involved.
2. I understand that it is my responsibility to consult with a physician prior to and regarding my participation in the Our Place Wellness Center. I represent and warrant that I am physically fit and have no medical condition that would prevent my full participation in the Our Place Wellness Center.
3. In consideration of being permitted to participate in the Our Place Wellness Center, I agree to assume full responsibility for any risks, injuries or damages, known or unknown, which I might incur as a result of participating in the Our Place Wellness Center.
4. In further consideration of being permitted to participate in the classes offered by the Our Place Wellness Center, I knowingly, voluntarily and expressly waive any claim I may have against the instructor or The Arc of San Diego for injuries or damages that I may sustain as a result of participating in these classes.
5. I, my heirs, or legal representative of such forever release, waive, discharge and covenant not to sue The Arc of San Diego and its officers, directors, employees, agents, sponsors, in-kind donors or volunteers and any of its Our Place Wellness Center's instructors for any injury or death caused by their negligence or other acts.

I have read the above release and waiver of liability and fully understand its contents. I voluntarily agree to the terms and conditions stated above.

Signature of participant: _____ **Date:** _____

If participant is under 18 or conserved: - As legal guardian of this participant, I consent to the above terms and conditions:

Signature of guardian/conservator: _____ **Date:** _____

OUR PLACE WELLNESS CENTER CLASS REGISTRATION

Please note: Due to limited class space, participants are registered for Our Place classes on a first come, first served basis. Our Place staff will take every effort to match each participant with their preferred class choices. However, some participants may not be enrolled in all top 3 class choices.

****Please RANK each class in order of preference. 1 = Most Preferred Class; 7 = Least Preferred Class ****

Adaptive Yoga: 45 minute group class led by a certified yoga instructor in the Our Place yoga studio. Class focuses on improving flexibility and mental strength.

Adaptive Fitness: 45 minute group class held in the Our Place adaptive gym. Class focuses on improving strength through weight lifting and cardiovascular exercise.

Functional Fitness: 45 minute group class held outdoors. Class focuses on improving functional movements and range of motion using “every day” items.

Healthy Cooking: 45 minute group class led by a registered dietician in the Our Place Café. Class focuses on improving each participant’s nutritional plan through simple, daily strategies and hands-on cooking classes.

Art Therapy: 45 minute group class led by a certified art therapist. Class focuses on improving overall well-being through artistic movements and art projects.

Music Therapy: 45 minute group class led by a certified music therapist. Class focuses on improving overall well-being through the power of music and therapeutic movements.

Adaptive Zumba: 45 minute group class led by a certified Zumba instructor. Class focuses on improving cardiovascular strength through aerobic/dance movements to rhythmic music.

Participant Name: _____ Nickname: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Primary Phone: _____ Other Phone: _____

Email Address: _____

Name of Parent/Guardian (if applicable): _____ Relationship: _____

Phone: _____ Email: _____

24 HR Emergency Contact: _____ Relationship: _____

Primary Phone: _____ Other Phone: _____

*Alternate Responsible Party: _____ Phone: _____ Relationship: _____

Name of individual filling out this form: _____ Date: _____

Primary Phone: _____ Email: _____