Duke Integrative Medicine

Client Agreement and Waiver
With Brief Medical History

In our commitment to support your health and well being, before using our facility, we would like to learn a little about your medical history.

Date_____

Name_____

Mailing Address_____

City_____ State_____ Zip_____

Phone: (W) _____ (H) _____

Email address: _____

Please answer the following seven questions

YES	NO		
☐	☐	1.	Has your doctor ever said you have heart trouble?
☐	☐	2.	Do you frequently have pains in your heart and chest?
☐	☐	3.	Do you often faint or have spells of severe dizziness?
☐	☐	4.	Has a doctor ever said your blood pressure was too high?
☐	☐	5.	Has your doctor ever told you that you have a bone or joint problem such as arthritis that has been aggravated by exercise or might be made worse by exercise?
☐	☐	6.	Is there any good physical reason not mentioned here why you should not follow an activity program even if you wanted to?
☐	☐	7.	Are you over age 65 and not accustomed to vigorous exercise?

Client Agreement/Waiver

The undersigned client agrees to abide by the guidelines of Duke Integrative Medicine, including the completion of the above medical questionnaire.

The undersigned client agrees that all use of Duke Integrative Medicine facilities, services and programs shall be undertaken at his (her) sole risk and Duke Integrative Medicine shall not be liable for any injuries, accidents or deaths occurring to clients arising either directly or indirectly out of utilizing Duke Integrative Medicine's facilities, services and programs. The client, for himself (herself) and on behalf of his (her) executors, administrators, heirs and assigns, does herby expressly release, discharge, waive, relinquish, and covenants not to sue Duke Integrative Medicine, its officers and agents for such claims, demands, injuries, damages or cause of action, with respect to use of Duke Integrative Medicine's facilities, programs and services.

The undersigned Duke Integrative Medicine client declares that they have completed the medical questionnaire above as required by Duke Integrative Medicine and that they declare they are physically able to participate in physical activity and or utilize the whirlpool and dry/wet sauna rooms. Furthermore, Client declares that Duke Integrative Medicine has advised client to obtain a medical clearance in the event they answer yes to any of the medical history questions, or they are unsure of their physical health and that client maintains that he (she) is physically capable of pursuing physical activity in Duke Integrative Medicine without such steps being taken or has done so.

Client signature_____ Date_____