Exercise Emphasis

__________ I understand that my participation in the Quadra Health Institute's(QHI) Movement Health Program is a required part of an integrated medical intervention to help manage my specific symptoms / disability / limitations and/or conditions.

__________ I understand that my participation in the QHI Movement Health Program will require being an active participant in the adopting of long term healthy lifestyle modifications. This includes the regular practice of an exercise program, improved nutrition and changes in my behaviors, attitudes and beliefs regarding my personal responsibility in the management of my health.

__________ I understand that this participation may include maintaining a log that tracks my exercise, nutrition and other lifestyle factors. This is so that if necessary Quadra Health Institute can make appropriate modifications to my medical interventions through the insight gained from the QHI Movement Health Program.

__________ I understand that the log used to track my progress towards the implementation of healthful lifestyle modifications may be included in my personal medical record and Quadra Health Institute will ensure the confidentiality of my information.

__________ I understand that in the course of the evaluations, treatments and participation in interventions by Quadra Health Institute and overall healthful lifestyle modification that I may encounter some discomfort and may in some instances have some temporary increased pain.

__________ I understand that the focus of my treatment is not on medications alone. That the role of being prescribed medications and/or injections is to help improve my specific symptoms / disability / limitations and/or conditions while I am progressing towards making lasting lifestyle modifications towards better health.

__________ I understand that the continued prescription and use of medications is contingent upon my compliance in the participation of the QHI Movement Health Program.

__________ I understand that if I use tobacco products I will participate in a smoking cessation program and may be asked to document participation in such smoking cessation program.

__________ I understand that my specific symptoms / disability / limitations and/or conditions may require psychological or cognitive behavioral interventions in order to help me adjust living with a chronic painful condition so that I may achieve a healthy lifestyle.

__________ I am committed to being accountable for my health through the participation in the Quadra Health Institute's Movement Health Program.

Patient:____

3/15 AL/TJ