Adventure Therapy Institute

Name of Participant ___________________________________

Confidential HEALTH questionnaire

Your safety is of utmost importance to us. For this reason it is essential that you share full details of your medical situation with us. Please complete, sign and return a scanned copy by email to info@ati.academy and ensure you have up to date health insurance and first aid kit for your trip.

Seminars, Courses and Workshops held by Adventure Therapy Institute are mainly taking place close to and in nature. Sometimes these seminars and courses ask for more physical activity. Participants with health issues, disabilities or chronic diseases can participate in the programs but only if ATI has full information about the health situation of the participants. All information in the questionnaire is confidential and only for the use to prevent physical harm from the participants.

Date of today:	
Name and date of program/ course:	
Pre-name/ Surname:	
Name	
Street	
Postal code	
City	
Country	
Email	
Telephone home	
Telephone mobil	
Your Birthday	
sex	

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In case of emergency we use:

Name of your doctor:	
Phone numer of your doctor	
Medical insurance co:	
Group/ policiy N°	
Notify also: Name	
Does your doctor know you are going to participate in this retreat:	
In case of emergency, notify: Name	
Realationship	
Phone number	
Does your emergency contact person know you will participate:	

Health questionnaire

Are you under the care of a physician?	☐ - YES	☐ - NO
Have you described this program to your physician and discussed your plans to participate?	☐ - YES	☐ - NO
Does your physician approve of you participating?	☐ - YES	☐ - NO
Please describe any discussions you've had:		

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Are you seeing a therapist at present?	☐ - YES	☐ - NO
Would your therapist disapprove of you entering this activity?	☐ - YES	☐ - NO
If yes, please describe why:		

Do you have any history of emotional or psychological problems?	☐ - YES	☐ - NO
If yes, please describe:		
Please list any medications you are taking for psychological problems:		

Are there any reasons why you should not fast or live alone?	☐ - YES	☐ - NO
If yes, please describe:		

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Were you hospitalized in the last two years?	☐ - YES	☐ - NO
If yes, please describe:		

Have you ever had a heart attack of any kind, or been told by a doctor that you have high blood pressure, a heart murmur or heart disease?	☐ - YES	☐ - NO
If yes, please describe:		

Have you ever experienced a seizure of any kind?	☐ - YES	☐ - NO
If yes, please describe:		

Do you have allergic or anaphylactic reactions to any insults, such as environmental substances, foods, drugs, insect bites or stings?	☐ - YES	☐ - NO
If yes, please describe:		

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Do you have hemophilia or any other disorder that impairs blood-clotting?	☐ - YES	☐ - NO
If yes, please describe:		

Do you have a lung disease or any kind of breathing problem?	☐ - YES	☐ - NO
If yes, please describe:		

Do you have any muscle, joint, or bone related disabilities?	☐ - YES	☐ - NO
If yes, please describe:		

Do you have trouble with headaches?	☐ - YES	☐ - NO
If yes, please describe:		

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Do you have any kidney disease?	☐ - YES	☐ - NO
If yes, please describe:		

If you walked on the level for a mile at an average pace would you get out of breath, have pains in the chest, develop muscle fatigue or have pains in your legs?	☐ - YES	☐ - NO
Describe your degree of fitness in your own words:		

Do you have hypoglycemia or diabetes?	☐ - YES	☐ - NO
If yes, please describe:		

Do you have any other chronic disease that, in any way, threatens your health?	☐ - YES	☐ - NO
If yes, please describe:		

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Are you taking <u>any</u> medication at the present time?	☐ - YES	☐ - NO
If yes, specify each drug, the dose and the reason for taking:		

Any dietary preferences or needs?	☐ - YES	☐ - NO
If yes, please describe:		

Medical data:

Blood group: ______________________________

Do you have:
- ☐ asthma
- ☐ diabetic
- ☐ epilepsy
- ☐ sleep walking
- ☐ HIV
- ☐ ADHD
- ☐ allergy — description: ______________________
- ☐ heart diseases — description: ______________________
- ☐ other — description: ______________________

What medication do you take for this:

Medication: ______________________

Time when to take it: ______________________

Amount: ______________________

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Medication: ____________________________

Time when to take it: ____________________________

Amount: ____________________________

Are some of these medical issues asking special care during the programme or in case of accident from the staff?

If yes, how? ____

Are you taking other medication? If yes, which?

☐	for heart, airways, blood dilatators	which:	______________________
☐	against depression, sleeping pills or tranquillizers	which:	______________________
☐	against psoriasis, eczema, rheumatic	which:	______________________
☐	cortisone or other immunisation stopping medication	which:	______________________
☐	others	which:	______________________

Vaccinations: ☐ tetanus year: ______________________

Are you allergic for some medication? If yes, which: ____________________________________

Is there other medical information we have to be aware of?

____

I can

☐ swim

☐ not swim

I can

☐ bike

☐ not biking

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10 km by feet/ trekking,

I can go in my own rhythm/ tempo in_______________________ minutes

I can go with packages / backpack __________________________ minutes

This information is accurate and complete. I agree to cooperate with the retreat facilitators to design a wilderness practice with full consideration of my health history and health concerns. I give my permission to ATI guides and course leaders on this trip to seek emergency medical diagnosis or treatment for me in the event that I am unconscious or unable to make my own decisions. Our role in offering medical treatment will be limited to emergency first-aid and either transportation to the nearest medical facility or contacting such a facility to arrange emergency transport.

____

DATE/ SIGNATURE

(If under 18 years old, must be parent or guardian's signature)