

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	

Name of Participant _____

In case of emergency we use:

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

Health questionnaire

Are you under the care of a physician?	<input type="checkbox"/> - YES	<input type="checkbox"/> - NO
Have you described this program to your physician and discussed your plans to participate?	<input type="checkbox"/> - YES	<input type="checkbox"/> - NO
Does your physician approve of you participating?	<input type="checkbox"/> - YES	<input type="checkbox"/> - NO
Please describe any discussions you've had:		

Name of Participant _____

Are you seeing a therapist at present?	<input type="checkbox"/> - YES	<input type="checkbox"/> - NO
Would your therapist disapprove of you entering this activity?	<input type="checkbox"/> - YES	<input type="checkbox"/> - NO
If yes, please describe why:		

Do you have any history of emotional or psychological problems?	<input type="checkbox"/> - YES	<input type="checkbox"/> - 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?	<input type="checkbox"/> - YES	<input type="checkbox"/> - NO
If yes, please describe:		

Name of Participant _____

Were you hospitalized in the last two years?	<input type="checkbox"/> - YES	<input type="checkbox"/> - 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?	<input type="checkbox"/> - YES	<input type="checkbox"/> - NO
If yes, please describe:		

Have you ever experienced a seizure of any kind?	<input type="checkbox"/> - YES	<input type="checkbox"/> - 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?	<input type="checkbox"/> - YES	<input type="checkbox"/> - NO
If yes, please describe:		

Name of Participant _____

Do you have hemophilia or any other disorder that impairs blood-clotting?	<input type="checkbox"/> - YES	<input type="checkbox"/> - NO
If yes, please describe:		

Do you have a lung disease or any kind of breathing problem?	<input type="checkbox"/> - YES	<input type="checkbox"/> - NO
If yes, please describe:		

Do you have any muscle, joint, or bone related disabilities?	<input type="checkbox"/> - YES	<input type="checkbox"/> - NO
If yes, please describe:		

Do you have trouble with headaches?	<input type="checkbox"/> - YES	<input type="checkbox"/> - NO
If yes, please describe:		

Name of Participant _____

Do you have any kidney disease?	<input type="checkbox"/> - YES	<input type="checkbox"/> - 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?	<input type="checkbox"/> - YES	<input type="checkbox"/> - NO
Describe your degree of fitness in your own words:		

Do you have hypoglycemia or diabetes?	<input type="checkbox"/> - YES	<input type="checkbox"/> - NO
If yes, please describe:		

Do you have any other chronic disease that, in any way, threatens your health?	<input type="checkbox"/> - YES	<input type="checkbox"/> - NO
If yes, please describe:		

Name of Participant _____

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

Any dietary preferences or needs?	<input type="checkbox"/> - YES	<input type="checkbox"/> - 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: _____

Name of Participant _____

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 dilators 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?



swim

bike

not swim

not biking

Name of Participant _____



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)