**CLIENT APPLICATION FORM**

The information obtained in this application will remain confidential. It will be used

Solely by the staff of “Stay *in Step, Spinal Cord Injury Recovery Center* " in determining program

eligibility.

Date: \_\_\_\_\_\_\_\_\_\_\_\_

Client name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_

Zip code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone: \_\_\_\_\_\_\_\_\_\_

Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Referred by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell Phone: \_\_\_\_\_\_\_\_\_\_\_ email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICAL INFORMATION**

Date of Injury: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Level of spinal cord injury: \_\_\_\_\_\_\_\_\_\_\_\_ Complete: \_\_\_

Incomplete: \_\_\_\_\_\_ ASIA Level/Score: \_\_\_\_\_\_\_\_\_\_ Height: \_\_\_\_\_\_\_\_\_\_\_ Weight: \_\_\_\_\_\_\_\_

At what hospital were you treated? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Treating physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Any Rehabilitation Program: Yes: \_\_\_\_

NO: \_\_\_\_\_Where: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ From: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date last attended: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Describe your physical abilities:

Upper extremity: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Trunk (IE: Can you sit up?):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Lower Extremity: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Please list any physical problems:

Hypersensitivity\_\_\_\_ Osteoporosis/ Osteopenia \_\_\_\_\_ Pressure Sores/ Skin Breakdowns \_\_\_\_\_\_

Pain \_\_\_\_\_\_ Heterotrophic Ossification \_\_\_\_\_ Joint/ Muscle disorder \_\_\_\_\_ Obesity \_\_\_\_\_\_

Knee instability \_\_\_\_ Other Health issues \_\_\_\_\_\_

If yes, briefly explain symptoms:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Have you had a recent bone density assessment? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please attach a recent bone density scan with the doctor's interpretation.

**NOTE:** All clients over 6 months post injury must obtain a bone density assessment and are required to submit a copy of the bone density report with the doctor's interpretation before their first session at Stay In Step. We do not interpret bone density reports.

Please list all current medications, dosage, frequency and function you are talking:

**Medication Dosage mg/ Frequency Function**

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Please answer "yes" or "no" for the following. Please answer "yes" to those that apply to you at present or have applied to you in the past, with a brief explanation in the space provided.

Alcohol: Yes \_\_\_ NO \_\_\_\_, Frequency \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cigarette smoking: Yes \_\_\_ NO \_\_\_If yes, how many packs per day: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diabetes: Yes \_\_\_\_ NO \_\_\_\_ High Cholesterol: Yes \_\_\_\_ No \_\_\_

Obesity: Yes \_\_\_\_ NO \_\_\_\_ History of chest pain: Yes \_\_\_\_ No \_\_\_\_

Muscle tension: Yes \_\_\_\_\_ No \_\_\_\_\_ Thyroid: Yes \_\_\_\_ No \_\_\_\_

History of heart problems in the immediate family: Yes \_\_\_\_ NO \_\_\_

Tendon/ joint problems: Yes \_\_\_\_ No \_\_\_\_ Breathing/lung problems: Yes \_\_\_\_ NO \_\_\_

Hernia or any condition that may be aggravated by intense exercise: Yes \_\_\_\_ No \_\_\_\_

Ventilator Dependent: Yes \_\_\_\_\_ No \_\_\_\_\_

Are you aware of any disease or disorder that would complicate your participation in an intense exercise program?

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Are you currently involved in any recreational physical activities (IE: swimming, hand cycling, rugby, etc.)?

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Has your physician approved your participation in an intense exercise program? Yes \_\_\_\_\_ No \_\_\_\_\_\_

NOTE: This is required prior to you first session to *Stay in Step, Spinal Cord Injury Recovery Center*.

Is there any reason not mentioned here why you should not follow a regular exercise program?

If yes, briefly explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Please make any other comments you feel may be pertinent to your exercise program:

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I have completed this application to the best of my knowledge. I understand that if necessary,

“Stay *in Step, Spinal Cord Injury Recovery Center* " reserves the right to request medical clearance before beginning any exercise program, and has the right to deny my participation in the program if requests are not fulfilled. I also understand that participating in the program at " *Stay in Step, Spinal Cord Injury Recovery Center* " while under the influence of any uncontrolled substance (e.g. marijuana, etc.) is strictly prohibited.

Print Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If under 18, name of parent or guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Parent or guardian's signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_