ADAPT TRAINING | **THERAPY APPLICATION**

PERSONAL INFORMATION

Name: _____
(LAST) (FIRST) (MIDDLE)

Date of Birth: _____ Sex: M F

Permanent Address: _____

_____

Mailing Address: _____
(If different than permanent)

_____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email Address: _____

Preferred Method of Contact: _____

Emergency Contact:

Name: _____ Relationship: _____ Number: _____

Alternative: _____ Relationship: _____ Number: _____

How did you hear about us? _____

Current Condition: _____

Cause: _____

Duration of Condition/ Date of Onset: _____

Have you seen a doctor for this condition? Yes No

Treating Physican: _____ Contact Number: _____

General Practitioner: _____ Contact Number: _____

Current Treatment(s): _____

Past Treatment(s) for Current Condition: _____

Insurance Provider: _____ Contact Number: _____

Current Activity Level: _____

Possible Start Date and Scheduling Preferences (morning, afternoon, etc): _____

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MEDICAL HISTORY

Please answer 'Yes' or 'No' to the following. Indicate 'Yes' for those that apply to you at present or have applied to you in the past and explain in the space provided.

Condition			Explanation
History of chest pain	Yes	No	
History of heart disease or any other heart/valve disorder	Yes	No	
Any chronic illness or condition	Yes	No	
High/Low blood pressure	Yes	No	
Stroke/TIA	Yes	No	
Bleeding disorder	Yes	No	
Deep Vein Thrombosis (DVT)	Yes	No	
Kidney condition	Yes	No	
Menstrual problems	Yes	No	
Pregnancy	Yes	No	
Lung conditions/disease	Yes	No	
Asthma	Yes	No	
Do you smoke?	Yes	No	How often?
Ear/Sinus condition(s)	Yes	No	
Visual Impairment	Yes	No	
Auditory Impairment	Yes	No	
Seizures	Yes	No	
Diabetes	Yes	No	
Thyroid condition	Yes	No	
High cholesterol	Yes	No	
Muscular/Skeletal disorder(s)/condition(s)	Yes	No	
Osteoporosis/Osteopenia	Yes	No	
History of pathological fracture	Yes	No	
Hardware/Joint Replacement	Yes	No	
Hernia	Yes	No	
Difficulty with physical exercise	Yes	No	
Obesity	Yes	No	
Neurological disorder	Yes	No	
Use of adaptive equipment	Yes	No	
Wheelchair dependent	Yes	No	
Bowel/bladder incontinence	Yes	No	

Surgeries and Hospitalizations

Date: _____ Reason: _____ Location: _____
Date: _____ Reason: _____ Location: _____
Date: _____ Reason: _____ Location: _____

List all current medications/supplements

Name	Dose	Frequency	Start month/year	Reason for taking

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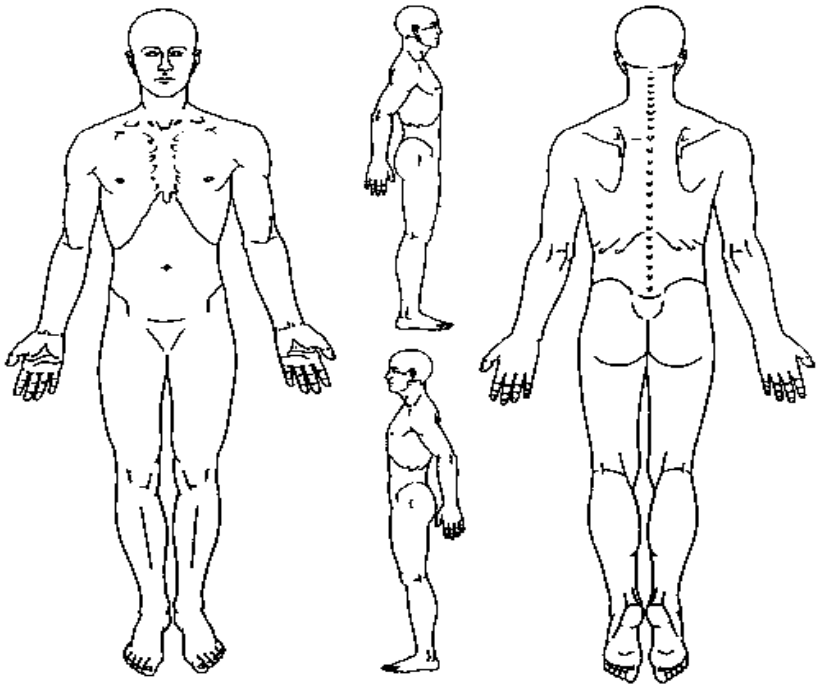
Medications/supplements continued

CURRENT SYMPTOMS

Please mark where you are currently feeling symptoms. Write in descriptions of your symptoms, (for example: sharp, dull, aching, radiating, shooting, throbbing, tingly, numb) and rate the intensity of symptoms from 1-10.



Additional Information

_____

_____

_____

I, _____ (name of participant), acknowledge that I have voluntarily elected to participate in ADAPT Therapy exercise routines operated by ADAPT. I have completed this application to the best of my knowledge in an effort to make known any medical conditions that may limit my participation in ADAPT Therapy. I further understand that ADAPT Therapy has the right to terminate my program at any time.

_____ SIGNATURE

_____ DATE

IF YOU HAVE BEEN DIAGNOSED BY A PHYSICIAN WITH A NEUROLOGICAL DISORDER OR CONDITION, PLEASE CONTINUE TO PAGE 4

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NEUROLOGICAL CONDITIONS/DISORDERS - ONLY

Neurological Condition: _____

Nature of Condition (disease, trauma, injury, etc.): _____

Date of Diagnosis/Injury: _____ Hardware Present? Where? _____

Are you currently participating in physical therapy? Yes No

If yes, where: _____ Contact Number: _____

Type/Frequency of Therapy: _____

_____

Do you use an assistive device for mobility? Yes No

Briefly describe type of device used and ability: _____

_____

Briefly describe areas in your body in which you experience altered sensation: _____

_____

_____

Briefly describe areas in your body in which you experience muscle weakness or impaired connection: _____

_____

_____

Do you experience muscle spasms? Yes No
Briefly explain: _____

_____

Do you experience pain (nerve or otherwise)? Yes No
Briefly explain: _____

_____

Do you experience Autonomic Dysreflexia (AD)? Yes No

Do you experience Urinary Tract Infections (UTI)? Yes No

Do you have a history of pressure sores? Yes No

Please know that it is your responsibility to notify ADAPT Therapy staff of any skin irritation/breakdown

Please initial that you understand this policy _____

Do you have Heterotrophic Ossification (HO)? Yes No
If 'Yes', please note location: _____

_____ _____ _____
NAME – PRINTED SIGNATURE DATE