



Upon completion, please fax to:

1-925-846-1851

Or mail to:

SCI-FIT/NEURO-FIT
3283 Bernal Ave, STE 105
Pleasanton, CA, 94566

Last Name

In an effort to provide the most safe and effective program, it is necessary for all clients to complete this application in its entirety. All information provided will remain confidential. If the client is under the age of 18, a parent or guardian must sign the application.

PERSONAL INFORMATION

Legal Name _____
Last First Middle (complete)

Are you applying for a trial week or permanent client position? Possible Start Date _____

Birthdate _____ / _____ / _____ E-mail Address _____
mm/dd/yyyy

Permanent Home Address _____
Number and Street

City or Town State Country Zip Code

If different from above, please give your mailing address for all admission correspondence

Mailing Address (from _____ / _____ to _____ / _____) _____
(mm/yyyy) (mm/yyyy) Number and Street

City or Town State Country Zip Code

Phone at mailing address (_____) _____ Permanent home phone (_____) _____
Area Code Number Area Code Number

Cell phone (_____) _____
Area Code Number

In case of emergency, please notify:
Name _____ Relationship _____

Phone (home) _____

MEDICAL INFORMATION

Height _____ Weight _____ Date of Onset _____ / _____ / _____
Mm/dd/yyyy

Neurological Disorder:
 Brain Injury CP MS Parkinson's SCI Spinal Tumor Stroke Transverse Myelitis Other

If CP, what type? _____

If Other, please describe _____

If SCI, Spinal Tumor, or Transverse Myelitis:
 Cause of Injury _____

Level of Injury _____ Complete Incomplete Asia Score _____

Current therapy: Yes No Where _____

Type/Frequency _____

Hospitalization since injury

| <i>Date</i> | <i>Reason</i> | <i>Location</i> |
|-------------|---------------|-----------------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Type of wheelchair: Manual Electric Power Assisted/Manual

Assistive standing/walking device

Yes _____
Briefly explain type

No _____
Briefly describe gait

Hospitalization of initial onset (if any)

Location of rehabilitation

Name

Address

City State Zip Code

Name

Address

City State Zip Code

Length of stay

Length of stay

from _____ / _____ / _____
mm/dd/yyyy

to _____ / _____ / _____
mm/dd/yyyy

from _____ / _____ / _____
mm/dd/yyyy

to _____ / _____ / _____
mm/dd/yyyy

Please list all current medications

| | | | | |
|---|-------------|-------------|-------------|--------------------|
| 1 | <i>Name</i> | <i>Dose</i> | <i>Freq</i> | <i>Start mo/yr</i> |
| 2 | <i>Name</i> | <i>Dose</i> | <i>Freq</i> | <i>Start mo/yr</i> |
| 3 | <i>Name</i> | <i>Dose</i> | <i>Freq</i> | <i>Start mo/yr</i> |
| 4 | <i>Name</i> | <i>Dose</i> | <i>Freq</i> | <i>Start mo/yr</i> |
| 5 | <i>Name</i> | <i>Dose</i> | <i>Freq</i> | <i>Start mo/yr</i> |
| 6 | <i>Name</i> | <i>Dose</i> | <i>Freq</i> | <i>Start mo/yr</i> |
| 7 | <i>Name</i> | <i>Dose</i> | <i>Freq</i> | <i>Start mo/yr</i> |

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:

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 Blood Pressure: Yes No
 Low Blood Pressure: Yes No
 Difficulty with physical exercise: Yes No
 History of Pathological fracture: Yes No
 Pregnancy (now or within the last 3 months): Yes No
 Breathing/Lung Problems: Asthma: Yes No
 Any other disease of the lungs: Yes No
 Muscle, joint or back disorder, or any previous injury still affecting you: Yes No
 If yes, please explain: _____

Diabetes: Yes No
 Thyroid condition: Yes No
 High Cholesterol: Yes No
 Obesity: Yes No
 Hernia, or any condition that may be aggravated by intense exercise: Yes No

Has your doctor cleared you to participate in an intense exercise program?

***A physician's release is required to participate in SCI-FIT or NEURO-FIT.**

***Please initial if you understand this policy_____**

Sensory and Motor Conditions

Briefly describe areas of the body that have *normal* sensation, or are not affected by your condition

Briefly describe the areas of the body that have *little or no* sensation, or are severely affected by your condition

Briefly describe areas of the body where motor control is *normal*, or not affected by your condition

Briefly describe areas of the body that have *little to no* motor control, or are severely affected by your disorder

Any spasticity? Yes No

If Yes, briefly explain

Any tone? Yes No

If Yes, briefly explain

Any pain? Yes No

If Yes, briefly explain

Any Autonomic Dysreflexia? Yes No

If Yes, briefly explain symptoms

History of Urinary Tract Infections? Yes No

Most recent

History of Pressure Sores/Skin Breakdowns? Yes No

****Please understand that it is your responsibility to notify SCI-FIT or NEURO-FIT of any skin irritations/possible pressure sores. Please initial if you understand this policy_____***

If Yes, briefly explain what area

Any Heterotrophic Ossification? Yes No

Location

Have you been diagnosed with Osteoporosis/Osteopenia? Yes No

****SCI-FIT and NEURO-FIT require you to obtain a bone scan if you have used a wheel chair for over a year. *Please initial if you understand this policy_____***

Deep Vein Thrombosis? Never Past Present

Bladder:

Do you have Bladder/Bowel control? Yes No

What are your goals and / or health concerns for coming to SCI-FIT or NEURO-FIT?

What experiences have you had with alternative medicine (acupuncture, massage, etc.)?

Qualifications

All neurological disorders will be assessed on a case-by-case basis. The primary qualifications that must be met in order to become a client at SCI-FIT or NEURO-FIT are the following:

- The client must possess some level of cognitive function (intellectual process by which one becomes aware of, perceives, or comprehends ideas, and involving all aspects of perception, thinking, reasoning, and remembering)
- Client must be cleared by a physician to participate in an intense exercise therapy program
- Client must be cleared by a physician to perform weight-bearing activities through the upper and lower extremities (a bone scan will be required for those 1 or more years in a wheelchair or non-load bearing environment)
- Client must possess a positive attitude and willingness to work hard

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 SCI-FIT or NEURO-FIT. I further understand that SCI-FIT/NEURO-FIT has the right to terminate my program at any time.

Signature _____

Date _____