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

Date	*Reason*	*Location*
Date	*Reason*	*Location*
Date	*Reason*	*Location*
Date	*Reason*	*Location*

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)

_____
Name

_____
Address

City *State* *Zip Code*

Length of stay

from_____/_____/_____
mm/dd/yyyy

to _____/_____/_____
mm/dd/yyyy

Location of rehabilitation

_____
Name

_____
Address

City *State* *Zip Code*

Length of stay

from_____/_____/_____
mm/dd/yyyy

to _____/_____/_____
mm/dd/yyyy

Please list all current medications

	Name	*Dose*	*Freq*	*Start mo/yr*
1				
2				
3				
4				
5				
6				
7				

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 physican'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 severly 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 **U**rinary **T**ract **I**nfections? ☐ 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

<u>Bladder:</u>

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_____