

SCI Recovery Project Client Application

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This application is needed for your safety, and to help guide the staff here at SCI Recovery Project to ensure you get the best results from your program. Please answer all questions to the best of your knowledge. If there are any questions or concerns contact your physician for advice. Be advised there is a required medical clearance form that will need to be sent along with this application. Thank you for taking the time to complete this form, when ready you can either return it to us via: e-mail, fax, or postal.

- E-mail: info@scirecoveryproject.com
- Phone: (303) 286-0918 (fax available upon request)
- Postal Address: SCI Recovery Project
866 East 78th Ave.
Denver, CO. 80229

Once we have received your application we will review it, and discuss the details with you over the phone or e-mail.

Personal Contact:

Clients Name: _____ Age: _____
Home Phone: (_____) _____ Cell Phone:(_____) _____
Address: _____ City: _____
State: _____ Country: _____
Zip Code: _____ E-Mail: _____
Emergency Contact: _____
Phone: (_____) _____

Personal Information:

Date of Injury: _____
Level of Injury: _____ Asia Score: _____
Incomplete or Complete: _____

SCI Recovery Project Client Application

How were you Injured? _____

What hospital were you treated at? _____
Previous Rehabilitation: _____ How long: _____
Benefits of Rehab: _____

List any Concerns you may have that we should consider while planning your appropriate exercise program: _____

Please list any exercise you have done prior to your injury (Gives us an idea of your interests): _____

Honorable Agreement:

I have read and completed this application to the best of my knowledge. I realize that it is in my best interest to complete these forms honestly. I understand that I need to include any illnesses, disorders, or health issues which may not be included on these forms. I will take full responsibility to any false responses to any of the questions in these forms, and do not hold it to SCI Recovery Project trainers to be liable.

SCI Recovery Project Client Application

Please Print Name Clearly:

Signature:

Date:

If under 18, name of Parent or Guardian :

Relationship:

Parent or guardian signature:

Date:

How did you hear about SCI Recovery Project? _____

*The information in this application is confidential and is protected under the Privacy Act. The information is used solely by the staff of SCI Recovery Project in determining program eligibility.

SCI Recovery Project Client Application

The following Medical Form needs to be filled out by your physician in order to give clearance to participate in a concentrated exercise program. It helps reduce any risks, and it opens up communication between us and your physician.

Medical History Form

Name: _____ Date: _____

Telephone: _____ Sex: _____

Date of Birth: _____ Age: _____ Height: _____ Weight: _____

In Case of Emergency Contact: _____ Relationship: _____

Address: _____ Phone: _____

Physician: _____ Specialty: _____

Address: _____ Phone: _____

Are you currently under a doctors Care? _____

If yes, explain: _____

When was the last time you had a physical examination? _____

Have you ever had an exercise stress test? _____

If yes, what were the results? _____ (normal/abnormal)

Do you take any medications on a regular basis? _____

If yes please list below all prescriptions along with dosage, and their function:

<u>Medication Type</u>	<u>Dosage mg/day</u>	<u>Function</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you been recently hospitalized? _____

Please put a check next to all that apply to you in the following health risk list:

- € Do you smoke? How often? _____
- € Are you pregnant?
- € Do you drink alcohol more than three times/week?
- € Is your stress level high?
- € Do you have osteoporosis?
- € Do you have high/low blood pressure?

SCI Recovery Project Client Application

- € Do you have high cholesterol?
- € Do you have diabetes?
- € Obesity?
- € Muscle, back, joint disorders? Location? _____
- € Any surgeries? Procedure done? _____ Date: _____
- _____ Date: _____
- _____ Date: _____
- _____ Date: _____

- € History of pathologic Fractures?
- € Any Chronic Illnesses? Explain: _____
- € Hernia?
- € Thyroid Condition?
- € History of chest pain?
- € History of Heart problems?
- € Rheumatic heart disease?
- € A heart murmur?
- € Chest pain with exertion?
- € Irregular heart beat or palpitations?
- € Lightheadedness or do you faint?
- € Abnormal shortness of breath?
- € Emphysema?
- € Epilepsy?
- € Asthma?
- € Back pain in upper/mid/lower back?
- € Rods/plates/cages in spine? How many: _____ Location: _____
- € Nerve pain? Location: _____

How intense (circle one): Very strong strong weak very weak

Please describe any movements including spasms (controlled or uncontrolled) you have in your upper extremities, core, and lower extremities:

***Important: Please attach a bone density report to this application, with your physician’s interpretation.**

Please Print name clearly: _____

Client Signature: _____ Date: _____

Physicians Signature: _____ Date: _____

SCI Recovery Project Client Application

Physician's Clearance Form

Please return this form to: SCI Recovery Project
866 East 78th Avenue
Denver, CO. 80229
Phone: (303) 286-0918

Date: _____

Patient's Name: _____ Age: _____

Date of last physical examination: _____

_____ This patient may participate fully in a physical activity program consisting of cardiovascular, strength, and flexibility training without limitation.

_____ This patient may participate in a physical activity program with the following limitations and/or recommendations: _____

Please include a brief description of any medical condition that might affect his/her physical activity program: _____

If this patient is on any medication that may affect the heart rate or the blood pressure response to exercise (elevating or suppressing), please indicate:

- I consider the above individual to be: _____ normal
_____ Cardiac patient
_____ Coronary heart disease
_____ Other (explain)

Please fill in the following information if available:

Result of last GXT _____

SCI Recovery Project Client Application

Blood Pressure _____

Glucose _____

Total serum cholesterol _____

HDL-C _____ LDL-C _____

Triglycerides _____

Physician's Signature _____ Date _____

*Note: This record must be stamped with a physician's official stamp or be accompanied by a typed letter on a physician's letterhead, documenting that a medical evaluation has been performed on the name client. THE PHYSICIAN'S CLEARANCE FORM WILL NOT BE ACCEPTED WITHOUT SUCH PROPER VERIFICATION.

SCI Recovery Project Client Application

Agreement and Release of Liability Form

1. In consideration of being allowed to participate in the activities and programs of SCI Recovery Project and to use its facilities, equipment and machinery, in addition to the payment of any fee or charge, I do hereby waive, release and forever discharge SCI Recovery Project and its directors, and employees from any and all responsibilities or liability from injuries or damages resulting from my participation in any activities or my use of equipment or machinery in the above mentioned activities. I do also hereby release all of those mentioned and any others acting upon their behalf from any responsibility or liability for any injury or damage to myself, including those caused by the negligent act or omission of any of those mentioned or others acting on their behalf or in any way arising out of or connected with my participation in any activities of SCI Recovery Project or the use of any equipment.

IF YOU UNDERSTAND AND AGREE, INITIAL_____.

2. I understand and am aware that strength, flexibility and aerobic exercise, including the use of equipment, is a potentially hazardous activity. I also understand that fitness activities involve the risk of injury and even death, and that I am voluntarily participating in these activities and using equipment and machinery with knowledge of the dangers involved. I hereby agree to expressly assume and accept any and all risks of injury or death.

IF YOU UNDERSTAND AND AGREE, INITIAL_____.

3. I do hereby further declare myself to be physically sound and suffering from no disease or illnesses that would prevent my participation or use of equipment or machinery except as hereinafter stated. I do hereby acknowledge that I have been informed of the need for a physician's approval for my participation in an exercise/fitness activity or in the use of exercise equipment and machinery. I also acknowledge that it has been recommended that I have a yearly or more frequent physical examination and consultation with my physician as to physical activity, exercise and use of exercise and training equipment so that I might have his/her recommendations concerning these fitness activities and equipment use. I acknowledge that I have either had a physical examination and have been given my physician's permission to participate or that I have decided to participate in activity and use of equipment and machinery without the approval of my physician and do hereby assume all responsibility for my participation and activities, and utilization of equipment and machinery in my activities.

IF YOU UNDERSTAND AND AGREE, INITIAL_____.

SCI Recovery Project Client Application

Date _____

Signature _____

Name _____ (PLEASE PRINT)