TOGETHER WE MOVE

Client Application Form

In an effort to provide the safest and most effective programs, we require all clients to complete this application. Information contained on this application will remain confidential.

Please complete the application and send it via fax or email to:

- Fax: (716) 668-4SCI (4724)
- Email: admin@motionprojectny.org

After your application is reviewed, our office will contact you by e-mail or phone. The completion of this application does not guarantee your participation in our program.

CONTACT INFORMATION

Client Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone:_____

May we speak with anyone who may answer either of these phone numbers? ☐ YES ☐ NO

Email (Required): _____

(**Client's billing invoices are sent via email**)

Date of Birth: _____ Age: _____ Social Security Number: _____

Height: _____Weight:_____(lbs.)

Gender: Male _____ Female_____ Other_____

Marital Status: ◯ Single ◯ Married ◯ Divorced ◯ Life Partner ◯ Separated ◯ Widowed

EMERGENCY CONTACT INFORMATION:

PRIMARY EMERGENCY CONTACT:

Name: _____ Relationship to client: _____

Address: _____ Apt. #:_____

City, State, Zip code: _____

Phone (home): _____ Phone (cell): _____

OTHER CONTACT – not living with client:

Name: _____ Relationship to client: _____

Address: _____ Apt. #:_____

City, State, Zip code: _____

Phone (home): _____ Phone (cell): _____

MEDICAL INFORMATION

PRIMARY DIAGNOSIS:

Spinal Cord Injury _____

Level of Spinal Cord Injury: _____

Diagnosis: _____Complete or _____ Incomplete

Date of injury _____Asia Level/Score _____

Traumatic Brain Injury _____ Date of injury_____

Stroke _____ Date of stroke _____

Multiple Sclerosis _____ Type_____ When diagnosed _____

Cerebral Palsy _____

Other _____ When diagnosed _____

How were you injured?

_____

At what hospital were you treated? _____

City/State: _____

Treating physician: _____

Did you attend a rehabilitation hospital that specializes in your injury? ☐ YES ☐ NO

Which rehabilitation hospital did you attend?_____

Dates of treatment? From:_____To:_____Treating physician:_____

Date of Last Medical Examination: _____

Describe your physical abilities (Be as specific as possible, particularly with regard to your sensory and motor functions)

Upper extremity:

_____

_____

_____

Trunk (i.e.: Can you sit up?)

_____

_____

_____

Lower Extremity:

_____

_____

_____

Please list any physical problems or special considerations (ie: osteoporosis/osteopenia, knee instability, joint/ muscle disorder, obesity, hypersensitivity, rods in back, and other health issues or surgeries):

_____

_____

_____

What types of assistive devices do you currently use: _____

_____

Do you need assistance with any of the following?

Eating ◯ Bathing ◯ Grooming ◯ Dressing ◯ Travel ◯ Transfer ◯

Do you have muscle spasms? ☐ YES ☐ NO

If yes, are you taking medication? _____Type of medication? _____Pump_____?

Previous rehabilitation (if any):_____

Date Last Attended: _____

Results: _____

_____

_____

_____

BONE DENSITY ASSESSMENT

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 Motion Project. **We do NOT interpret bone density reports**.

Have you had a recent bone density assessment? ☐ YES ☐ NO

(Please attach a copy of the report with the doctor's interpretation.)

Results: Normal ____ Other: _____

MEDICATION(S)

Please list the type, dosage, frequency and function of all medications you are taking:

Medication Type	Dosage mg/day	Type (Function)

ADDITIONAL INFORMATION

Do you have any allergies? ☐ YES ☐ NO

If so, please list all allergies: _____

Please answer **YES or NO** to the following (past or present conditions apply):

History of chest pain: ☐ YES ☐ NO

History of Heart Disease or any heart/valve disorder: ☐ YES ☐ NO

History of chronic illness or condition: ☐ YES ☐ NO

High Blood Pressure: ☐ YES ☐ NO Low Blood Pressure: ☐ YES ☐ NO

Difficulty with physical exercise: ☐ YES ☐ NO

Osteoporosis: ☐ YES ☐ NO Osteopenia: ☐ YES ☐ NO

History of Pathological fracture: ☐ YES ☐ NO

Advice from your doctor **not** to exercise: ☐ YES ☐ NO

If YES, please explain: _____

Recent surgery (last 12 months): ☐ YES ☐ NO (Other than SCI) ☐ YES ☐ NO

If YES, please describe:

_____

Pregnancy (now or within the last 3 months): ☐ YES ☐ NO

Breathing/Lung Problems: ☐ YES ☐ NO Asthma: ☐ YES ☐ NO

Any other disease of the lungs?:

_____

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

Cigarette Smoking: ☐ YES ☐ NO If yes, how many packs per day:

High Cholesterol: ☐ YES ☐ NO Obesity: ☐ YES ☐ NO

History of heart problems in the immediate family: ☐ YES ☐ NO

Hernia or any condition that may be aggravated by intense exercise: ☐ YES ☐ NO

Do you have any pressure sores? ☐ YES ☐ NO

If yes, what is the stage and location_____?

NOTE: It is important that your trainer know if a pressure sore develops prior to or while attending Motion Project.

Are you aware of any disease or disorder that would complicate your participation in an exercise program, other than the medical conditions you have checked above? ☐ YES ☐ NO

If YES please explain: _____

_____

PHYSICAL EXERCISE

NOTE: A physician's written approval for physical exercise is REQUIRED prior to your first session at Motion Project. Please provide a note from your physician clearing you for exercise.

Has your physician approved your participation in an intense exercise program? ☐ YES ☐ NO

Are you accustomed to vigorous exercise? ☐ YES ☐ NO

Is there any reason not mentioned here why you should not follow a regular exercise program? ☐ YES ☐ NO

If YES please explain: _____

_____

_____

Are you currently involved in any recreational physical activities? ☐ YES ☐ NO

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

_____

_____

_____

_____

_____

_____

Application Agreement

I have completed this Application to the best of my knowledge in order to make known any diagnosed medical problems or characteristics that may increase the risk of health problems, signs or symptoms indicative of health problems and lifestyle behaviors related to positive or negative health, which will enable Motion Project to determine if medical clearance is needed before beginning an exercise program. I understand if necessary, Motion Project reserves the right to request medical clearance which may involve a bone scan and physician's evaluation and approval 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 Motion Project while under the influence of any uncontrolled substance or non-prescribed medication (e.g. marijuana) is strictly prohibited.

_____	_____
Client Name	If under 18, Name of Parent or Guardian
	_____
	Relationship to Client
_____	_____
Signature	Signature
_____	_____
Date	Date

Possible Start Date: _____ Length of Stay: _____

SURVEY

How did you hear about Motion Project?

☐ Referred by Doctor Name: _____

☐ Referred by Client Name: _____

☐ Online Search

☐ Facebook, Twitter, Instagram Name: _____

☐ Chat Room (i.e.: Cure Care) Name: _____

☐ Referred by Motion Project Staff Name: _____

☐ Other _____

The information in this application is confidential and protected under the Privacy Act. The information is to be used solely by the staff of Motion Project in determining program eligibility. If you have received this information in error, please destroy the documents or mail the originals to Motion Project, 4820 Genesee Street, Cheektowaga, New York 14225.