Enrollment Application

PART I

First Name: Last Name: Middle Initial

SSN# Date of Birth: Age: Gender:

Street Address/P.O. Box

City/State Zip:

Country Email Address:

Home Phone: Cell Phone: Work Phone:

Emergency Contact Name: Relation to applicant: Contact number:

Primary physicians name and address:

When was your last physical exam?

Past Rehabilitation: ____ YES ____ NO
Name of facility and dates attended: _____

Diagnosis (Injury, Condition, Disease)

Spinal Cord Injury _____
Cause of Injury: _____ Injury level: _____
Date of Injury: _____ ASIA level: _____
Where did you do your Rehab?_____

Traumatic Brain Injury: _____
Cause of Injury: _____ Date of Injury: _____

Stroke: _____
Date of injury: _____

Multiple Sclerosis: _____
Date of diagnosis: _____

Other: _____
Explain: _____

Functional Mobility (To be completed by applicant or POA)

Do you need assistance to do the following?

YES	NO		YES	NO	
____	____	Eat	____	____	Transfer to/from bed
____	____	Bathing	____	____	Transfer to/from commode
____	____	Grooming	____	____	Transfer to/from vehicle
____	____	Dress	____	____	Transfer to/from floor
____	____	Bowel Program			

Method of mobility?

Wheelchair ☐
Power (type, joystick): _____
Manual (type): _____

Walking ☐
Devices used: _____
Distance you can walk: _____ft/yds

Are you currently involved in any other therapy programs or exercise programs? (Includes at home routines)
YES____ NO____

Name of facility:_____ Frequency: _____

Exercise/Activities:_____
_____

Please state your goals for the program at Vertical Therapy:

_____
_____
_____
_____
_____

PART II Physician's Exercise and Activity Clearance Form

*FOR PHYSICIAN USE ONLY

Patient Name: DOB:

Physician Name: Facility Name:

Facility Address:

The above patient is cleared to participate in an intensive exercise therapy program:

☐ OK to participate with NO restrictions:

☐ OK to participate with the following restrictions:

Please check **ALL** that are acceptable:

☐ Cycle ergometer utilizing functional electrical stimulation (FES bike) for lower extremities
☐ Cycle ergometer utilizing functional electrical stimulation (FES bike) for upper extremities
☐ Full weight bearing
☐ Partial weight bearing
☐ Body weight supported treadmill training
☐ Aerobic or Cardiovascular exercises, HR restrictions? _____BPM
☐ Strength and endurance resistance training exercises

Physician's Signature: Date:

*FOR VERTICAL THERAPY USE ONLY

Client signature: Date:

Vertical Therapy Staff Signature: Date:

PART III Health History & Par-Q

Name: _____ Age: _____Height: _____ Weight: _____

Please check all that apply to blood relatives:

___ Allergies	_____Cholesterol issues	____ Heart Condition	____ Sudden Death
____Anemia	_____Diabetes	____ High Blood Pressure	
____Arthritis	_____Epilepsy	_____Obesity	

Do you have or have you ever had any of the following? (Please check all that apply)

___Abnormal Chest X-Ray	___Edema	___High Blood Pressure	___Post-Polio Syndrome
___Abnormal ECG	___Emphysema	___High Cholesterol	___Pulmonary issues
___Anemia	___Epilepsy	___Injuries to Arms	___Shortness of breath
___Angina or Chest Pain	___Excessive Bleeding	___Injuries to Head	___Sickle Cell Anemia
___Arthritis	___Excessive Bruising	___Injuries to Legs	___Skipped Heart Beats
___Asthma	___Gout	___Joint problems	___Spinal Cord Injury
___Back Injuries	___Headaches (frequent)	___Low Blood Pressure	___Stroke (CVA)
___Back Pain	___Heart Attack	___Lung Disease	___TBI/ABI
___Coronary Bypass	___Heart Disease	___Mental Problems	___Tuberculosis
___Diabetes	___Heart Murmur	___Muscle Spasms	___Vertigo
___Dizziness	___Hernia	___Paralysis	___Weight Issues

*Other conditions that we should know of:_____

Date of last physical exam:_____ Any abnormal results? ____ YES _____NO

If you answered NO, please explain:_____

What is your blood pressure? _____/_____mmhg _____Unknown

What is your resting heart rate? _____BPM _____Unknown

What is your cholesterol level? _____TC _____Unknown

Please list all medications you are currently taking and the dosage amount:

_____

_____

_____

_____

_____

_____

_____

Name of Physician(s): _____

Physician(s) phone number/fax number: _____

Is it ok to contact your physician if needed? ____YES ____NO

This section is designed to identify the small amount of adults for whom physical activity would be inappropriate and for those who should seek medical advice before participating in an intensive exercise therapy program.

YES	**NO**	
____	____	Has a doctor ever said that you should not participate in an exercise program?
____	____	Do you frequently have chest pain?
____	____	Do you often feel faint or dizzy?
____	____	Has a doctor ever said that you have a heart condition?
____	____	Has a doctor ever told you that you have any condition that would be aggravated by physical activity?
____	____	Are you over the age of 65 and not accustomed to physical exercise?

Do you know of any reason why you should not participate in an intensive exercise therapy program?

____YES ____ No If Yes, please explain:_____

Do you currently smoke? ____YES ____ NO If Yes, how many per day? _____

Are you pregnant? ____YES____ NO

Are you currently in an exercise program? ____YES ____NO

If Yes, what kinds of activities? _____

How often?_____

For what period of time? _____

Do you have muscle spasticity or tone? ____ YES ____ NO

If Yes, do they disrupt your daily life? ____YES ____ NO

Do you have skin breakdown or pressure sores? ____ YES ____ NO

If Yes, where and how severe?_____

*By signing here, you admit that all of the information filled in is honest and truthful. This application will remain in a secure location and will not be shared with anyone other than Vertical Therapy staff members (unless authorized by the client)

_____

Client signature: Date: