



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? _____

Vertical Therapy

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:

Vertical Therapy

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: