Adaptive Exercise Application

To provide the most safe and effective program, it is necessary for all prospective clients of the Adaptive Exercise Program to complete this application. All information provided will remain confidential. If the client is under the age of 18, or unable to complete independently, a parent, guardian, or power of attorney must sign the application. Please complete and return to NeuAbility.

866 East 78th Avenue, Denver, CO 80229
303-286-0918, info@neuability.org

Personal Information:

First Name, Last Name: _____ Date of Birth: ___/___/____

Home Phone: (_____) _____ Cell Phone:(_____) _____

Address: _____

City: _____ State: _____ Zip Code: _____

E-Mail: _____

Emergency Contact Name: _____

Emergency Contact Phone: (_____) _____ Relationship: _____

Date of Injury: ___/___/____ Level of Injury: _____ Incomplete: ◯ Complete: ◯

Asia Score: _____ How were you injured? _____

What hospital treated you? _____

Previous Rehabilitation: _____ How long: _____

Benefits of Rehab: _____

_____

List any concerns you may have that we should know about specific exercises, limitations in range of motion, endurance levels, and/or experience in training. This information will help us advise you in your own training plan:

_____

_____

_____

_____

Adaptive Exercise Application

Please list any specific goals and/or expectations you are seeking:

_____

_____

_____

_____

Please fill in your Medical History Information

Height:	**Weight:**	**Gender:** MALE / FEMALE
Physician Name:		**Physician Address:**
Physician Phone:		
Physician Specialty:		**Physician E-Mail:**
Wheelchair: Yes ◯ No ◯	**If YES:** Electric / Power or Push Assist / Manual	
Assistive Device: YES / NO		**If YES describe:**
Current Therapy: YES / NO		**If YES describe:**

Check YES/NO to the following, indicate YES for all that apply at present or have applied in the past.		
GENERAL HEALTH	**YES**	**NO**
History of chest pain	◯	◯
History of heart disease or any heart/valve disorder	◯	◯
High blood pressure	◯	◯
Low blood pressure	◯	◯
Difficulty with physical exercise/activity	◯	◯
History of pathological fracture	◯	◯
Pregnancy (now or in last 3 months)	◯	◯
Breathing/lung problems (Asthma)	◯	◯
Any other disease of lungs	◯	◯
Muscle, joints, or back disorder	◯	◯
Diabetes	◯	◯
Hernia, or any condition that may be aggravated by intense exercise	◯	◯
Osteoporosis or Osteopenia	◯	◯
Contractures limiting range of motion	◯	◯
Heterotrophic ossification	◯	◯
Seizure or Epilepsy	◯	◯
Lightheadedness or fainting	◯	◯

Adaptive Exercise Application

Pressure sore or skin breakdown	◯	◯
Deep vein thrombosis (DVT)	◯	◯
CVA or stroke	◯	◯
Traumatic brain injury	◯	◯
Spasm or spasticity:	◯	◯
Tone	◯	◯
Pain (general)	◯	◯
Pain (neuropathy)	◯	◯
Autonomic Hyperreflexia, or Autonomic Dysreflexia (AD)	◯	◯
Rods, plates, cages	◯	◯

CARE AND MEDICATION	**YES**	**NO**
Are you currently under a physician's care?	◯	◯
If yes, describe:		
Have you been hospitalized in the last 12 months?	◯	◯
If yes, describe:		

MEDICATION: Please list all medications you are currently taking.

MEDICATION	**DOSAGE/DAY**	**REASON**

Adaptive Exercise Application

MEDICATION - Continued	**DOSAGE/DAY**	**REASON**

Adaptive Exercise Application

Physician Release Form – following must be filled out by the participants physician prior to participation at NeuAbility

Dear Physician,

Your patient, _____, is interested in participating in an adaptive exercise program at NeuAbility, the goals of which are to improve muscular strength, balance, flexibility and functionality. NeuAbility offers one-on-one Adaptive Exercise and Open Gym programs that may include intense physical activity consisting of cardiovascular exercise, strength training, weight-bearing activities, flexibility training, gait training, vibration training, nutrition consultation, and Functional Electrical Stimulation (FES).

We are enclosing a statement of medical clearance for exercise and request that you indicate your patient's eligibility for this program. Please be sure to include any specific exercise recommendations or adaptations to address your patient's needs, and any pre-existing exercise or rehabilitative guidelines or protocols that have been established for this patient. Finally, it would be very helpful if you would identify the signs or symptoms of any unstable phases of the patient's medical condition that you feel would make exercise unsafe.

If you have any questions or recommendations regarding this exercise program or your patient's participation, please contact me, Dr. Jay Seller, at 303-286-0918. Thank you for taking the time to help establish a healthier lifestyle for your patient. We know you are busy and appreciate your time and attention in this matter.

Sincerely,

Jay Seller

Dr. Jay Seller
NeuAbility Exeuctive Director

In accordance with the Health Insurance Portability and Acountability Act, I hereby give my permission for the release of any information that my physician deems necessary to help with the establishment of a personalized exercise program at NeuAbility.

Participant's Signature: _____ Date: _____

Adaptive Exercise Application

STATEMENT OF MEDICAL CLEARANCE FOR EXERCISE

Participant's name: _____

Address: _____

Date of birth: _____

Diagnosis: _____

Physician's name: _____

Address: _____

Email: _____

Telephone number: _____

Please select:

- YES. My patient listed on this form, has no current unstable medical problems that are a contraindication to participating in an adaptive exercise or resistance-training program. I approve of and support his or her participation in this progressive strength, endurance, balance, flexibility-training exercise program, and I have discussed the signs and symptoms that would make an exercise program unsafe with my patient. These symptoms may or may not inlcude the following:
  _____
  _____
  _____

- NO. My patient listed on this form, is NOT eligible to participate in the exercise program due to his or her current medical status.

Please indicate any special recommendations or specific comments:

_____
_____
_____

_____ _____

Physician's signature Date

Adaptive Exercise Application

Participant Waiver and Release of Liability Form

I, _____, HEREBY ASSUME ALL RISKS OF PARTICIPATING IN ANY/ALL ACTIVITIES ASSOCIATED WITH NeuAbility, ITS EMPLOYEES, AND VOLUNTEERS. Including by way of example, but not limitation, any risks that may arise from ODINARY NEGLIGENCE OR CARELESSNESS on the part of the NeuAbility its employees or volunteers, from dangerous or defective equipment or property owned, maintained, or controlled by them, or because of their possible liability, which may arise during normal exercise and therapeutic activities at the SCI Recovery Project.

I HEREBY CERTIFY that I am physically fit, have sufficiently prepared or trained for participation in this activity, and have not been advised to not participate by a qualified medical professional. I certify that there are no current health-related reasons or problems, which preclude my participation in this activity. I further acknowledge that I will only participate in activities at the NeuAbility with which I am comfortable and pose no medical risk as known to me.

In consideration of my application and permitting me to participate in this activity, I hereby act for myself, my executors, administrators, heirs, next of kin, successors, and assigns as follows:
(A) I WAIVE, RELEASE, AND DISCHARGE from any and all liability, including but not limited to, liability arising from the ordinary negligence or fault of the entities or persons released, for my death, disability, personal injury, property damage, property theft, or actions of any kind which may hereafter occur to me including my traveling to and from this activity, THE FOLLOWING ENTITIES OR PERSONS: The NeuAbility and/or their directors, officers, employees, volunteers, representatives, and agents. I acknowledge that the NeuAbility and their directors, officers, volunteers, representatives, and agents are NOT responsible for the errors, omissions, acts, or failures to act of any party or entity conducting a specific activity on their behalf;
(B) INDEMNIFY, HOLD HARMLESS, AND PROMISE NOT TO SUE the entities or persons mentioned in the above paragraph from any and all liabilities or claims made as a result of participation in this activity, whether caused by the negligence of release or otherwise. All injuries associated with participation in activities at The NeuAbility are hereby covered by this Participant Waiver and Release of Liability Form.

I hereby understand The NeuAbility is not a medical treatment facility, but consent to receive medical treatment in the event of injury, accident, and/or illness during the activity which The NeuAbility or its employees may deem necessary to administer in their own judgment. I hereby release all claims associated with the medical treatment, or lack thereof, which The NeuAbility or its employees may administer.

I acknowledge that this Participant Waiver and Release of Liability Form will be used by the program holders, sponsors, and organizers of the activities in which I may participate, and that it will govern my actions and responsibilities during said activities. This Participant Waiver and Release of Liability Form shall be construed broadly to provide a release and waiver to the maximum extent permissible under Colorado law.

I CERTIFY THAT I HAVE READ THIS DOCUMENT AND I FULLY UNDERSTAND ITS CONTENT. I AM AWARE THAT THIS IS A RELEASE OF LIABILITY AND A CONTRACT THAT I SIGN OF MY OWN FREE WILL. I hereby further certify that all the information provided in this application is true and accurate to the best of my knowledge.

_____	_____
Signature of Participation	NeuAbility Signature
_____	_____
Date	Date
_____	_____
Parent/Guardian Signature	Date

(Signature of power of attorney or parent/guardian if applicant is under 18)