Phone: 708-467-0657 **Fax: 708-330-5046** www.NextStepsChicago.org

Group Exercise Intake Form

All patients must complete the medical health history form in its entirety prior to initiating participation in any group exercise classes. All information will remain confidential, unless a confidentiality release form is completed. If the participant is less than 18 years of age, a parent or legal guardian must sign.

PERSONAL INFORMATION **TODAY'S DATE: _____**

Participant Name:

Last *First* *Middle*

Date of birth: _____/_____/_____Age_____ Gender: Male ☐ Female ☐

Contact Email (print clearly): _____

Name of Spouse/Parent/Guardian/Caregiver (circle one): _____

Street Address:

Number and street:

City/Town: *State:* *Country:* *Zip Code:*

Primary phone number: (_____) _____ Email:

Secondary phone number: (_____) _____

IN CASE OF AN EMERGENCY, PLEASE NOTIFY:

Name: Relationship:

Phone #- Cell: (_____) _____-_____ Home: (_____) _____-_____

Email: _____

By signing this document, I give permission to Next Steps of O'connor Foundation, Neuro Adaptive Fitness Program, and or representatives of competing organizing committees, or other personnel to seek medical care on my behalf in the event of an emergency.

PHYSICIAN INFORMATION

Patient's Primary Physician: _____

Phone:_____ Fax:_____

Address:

_____

Has your doctor cleared you to participate in an intense exercise program?
Written consent is required from your physician that clears you for intense physical activity at NextSteps **Please initial your acknowledgement_____

MEDICAL INFORMATION

Height_____ Weight_____

Diagnosis: please circle and provide timeline as appropriate:

- Stroke :
  - Side of Body affected: Right / Left Dominant Hand Prior to Stroke: Right / Left
    Date of Stroke: Type of Stroke:
- Traumatic Brain Injury Date:
- Amputation Date:
- Arthritis Date:
- Cancer Date:
- COPD Date:
- Cerebral Palsy Date:
- Multiple Sclerosis Date:
- Parkinson's Disease Date:
- Spinal Cord Injury Date:
  - Level: Please Circle: Complete / Incomplete
  - Cause:
- Visual Impairment
- Other Injury, Procedure, or Diagnosis and cause:
- Seizures: YES/ NO
  - How many in the last 12 months?: Date of most recent:
- Diabetes: Y/ N Do you use insulin: YES / NO
- Heart Disease: YES / NO
- Asthma: YES / NO Do you use an inhaler: YES/NO

Is your injury: Congenital / Acquired ?

Please answer yes or no to the following. Indicate yes for those that **apply to you at present or have applied to you in the past:**

History of chest pain:	☐ Yes ☐ No
History of heart disease or any other heart valve disorder:	☐ Yes ☐ No
Do you have a pacemaker?	☐ Yes ☐ No
Do you have any metal in your body? i.e. plates, screws, etc.	☐ Yes ☐ No
Pulmonary Disease; Breathing/lung problems: (i.e. asthma	☐ Yes ☐ No
High Blood pressure:	☐ Yes ☐ No
Low blood pressure:	☐ Yes ☐ No
Difficulty with physical exercise:	☐ Yes ☐ No
History of pathological fracture:	☐ Yes ☐ No
Pregnancy (not or within the last 3 months):	☐ Yes ☐ No
Cancer	☐ Yes ☐ No
Allergies	☐ Yes ☐ No
Diabetes:	☐ Yes ☐ No
Thyroid condition:	☐ Yes ☐ No
High cholesterol:	☐ Yes ☐ No
Depression	☐ Yes ☐ No
Expressive Aphasia	☐ Yes ☐ No
Receptive Aphasia	☐ Yes ☐ No
Anemia	☐ Yes ☐ No

If you answered "YES" to any of the above, please explain:

_____

_____

Do you have a history of Hernia, or any condition that may be aggravated by intense exercise:

☐ Yes ☐ No

Muscle, joint or back disorder, or any previous injury still affecting you: ☐ Yes ☐ No

If yes, please explain:

_____

_____

Sensation:

If your **sensation** has been affected by your condition, briefly describe:

_____

_____

Do you have *muscle spasms*? Yes/No, if yes, please describe:_____

_____

Do you have *pain*: Please describe:

_____

History of Urinary tract infections? ☐ Yes ☐ No
Date of most recent_____

History of Pressure sores/Skin breakdown ☐ Yes ☐ No
If yes, please describe:

_____

Any current or past history of deep venous thrombosis? ☐ Yes ☐ No
Location:

_____

Hospitalization history since date of onset:

*1.*_____
Date *Reason* *Location*

2.

3.

Please list all current medications (Name, Dose, Frequency, start (month/year): You can also provide a detailed list if available

Medication	Dose/ Frequency	Start Date	Purpose

Do you have incontinence problems with:
Bowel ☐ Yes ☐ No
Bowel routine: _____
Bladder ☐Yes ☐No
Bladder routine: _____

WALKING & BALANCE

Are you able to walk? If so, what device do you use (i.e. Walker, cane, crutches, braces, etc.):

Do you use a wheelchair? YES NO

If so, what type: ☐ Manual ☐ Electric

Do you use a brace? YES NO
Have you fallen in the past year? YES NO

Have you fallen in the past month? YES NO When:

Have you stumbled recently or are you fearful of falling? If yes, Please explain:

OTHER:

Do you smoke? Yes No

Are you currently receiving physical therapy? Y /N If yes, where?:

Are you interested in Neuro Adaptive Fitness and Wellness or Physical Therapy Rehabilitation programs? Y/N If yes, please circle which or both.

PARTICIPANT QUALIFICATIONS:

All neurological disorders will be assessed on a case-by-case basis. The primary qualifications that must be met in order to become a patient at NextSteps are the following:

The participating individual:

1) Must possess some level of cognitive function (intellectual process by which one becomes aware of, perceives, or comprehends ideas, and involving all aspects of perception, thinking and reasoning and remembering).
2) Must be cleared by a physician to participate in an intense exercise therapy program
3) Must be cleared by a physician to perform weight-bearing activities through the upper and lower extremities (a bone density scan will be required for those 1 or more years in a wheelchair or non-load bearing environment.
4) Must possess a positive attitude and willingness to work hard

I have completed this application to the best of my knowledge in an effort to make known any medical conditions that may limit my participation in Next Steps.

If under 18 years of age, parent or guardian must sign:

Parent/guardian signature: _____

INFORMED CONSENT AGREEMENT

Thank you for choosing to use the facilities, services, or programs of NEXT STEPS CHICAGO. We request your understanding and cooperation in maintaining both your and our safety and health by reading and signing the following informed consent agreement.

I, the undersigned, declare that I intend to use some or all of the activities, facilities, programs, and services offered by NEXT STEPS CHICAGO and I understand that each person, (myself included), has a different capacity for participation in such activities, facilities, programs, and services. I am aware that all activities, services, and programs offered are educational, recreational, or self-directed in nature. I assume full responsibility, during and after my participation, for my choices to use or apply, at my own risk, any portion of the information or instruction I receive.

I understand that part of the risk involved in undertaking any activity or program is relative to my own state of fitness or heath (physical, mental, or emotional) and to the awareness, care and skill with which I conduct myself in that activity or program. I acknowledge that my choice to participate in any activity, services, and program of NEXT STEPS CHICAGO brings with it my assumption of those risks or results stemming from this choice and the fitness, health, and awareness, care, and skill that I possess and use. **I further understand that personnel, who may not be licensed, certified, or registered instructors or professionals sometimes conduct the activities, programs, and services offered by NEXT STEPS CHICAGO. I accept that fact that the skills and competencies of some employees and/or volunteers will vary according to their training and experience and that no claim is made to offered assessment or treatment of any mental or physical disease or condition by those who are not duly licensed, certified, or registered and herein employed to provide such professional services.**

I recognize that by participating in the activities, facilities, programs, and services offered by NEXT STEPS CHICAGO, that I may experience potential health risks such as transient light-headedness, fainting, abnormal blood pressure, chest discomfort, leg cramps, and nausea and that I assume willfully those risks. I acknowledge my obligation to immediately inform the nearest supervising employee of any pain, discomfort, fatigue, or any other symptoms that I may suffer during and immediately after my participation. I understand that I may stop or delay my participation in any activity or procedure if I so desire and that I may also be requested to stop and rest by a supervising employee who observes any symptoms of distress or abnormal response.
I understand that I may ask any questions or request further explanation or information about the activities, facilities, programs, and services offered by NEXT STEPS CHICAGO at any time before, during, or after my participation.

I declare that I have read, understood and agree to the contents of this informed consent agreement in its entirety.

x / /

Patient / Responsible Party **Date**