Medical Statement Client Record (Confidential Information)

NOTE: Completion of this form does not guarantee your participation in our program. All forms will be reviewed by the Director of Training and Management to determine client participation. NextStep Raleigh, and its representatives solely determine membership in our programs and reserves the right to refuse service.

Personal and Contact Information **(All information must be completed to be submitted for review.)**

Date: ______________________

First & Last Name: ____

Date of Birth (mm/dd/yy): _________________________ Age: ________________

How did you come to learn about NextStep Raleigh? ____

Address:____

City: _____________________________State: __________ Zip Code: ____________________________________

Home Phone: _______________________________ Cell Phone: ____

Email (Required): ____

In case of emergency, please notify:

First & Last Name: ____

Relationship to You: ____

Phone (home): ____________________(work): ____________________(cell): ____________________________

Medical Information

Current Height: ______________ Current Weight: _________________ Gender: ______________

Neurological Disorder (Check all that apply)

- □ Spinal Cord Injury
- □ Traumatic Brain Injury
- □ Multiple Sclerosis
- □ Stroke
- □ Cerebral Palsy
- □ Other: __________________________________

If Spinal Cord Injury, cause of injury: ____

Level of injury: ____

ASIA score: (at time of injury) ___________ ASIA score: (Current) _____________

If Stroke, hemorrhagic or Ischemic: ____

Affected areas of the brain: ____

If Multiple Sclerosis, what type? ____

Date of Injury/Diagnosis: ____

Hospital where initially treated: ____

Treating physician: ________________________ City & State ________________

Dates of Stay: From: __________to: ________________

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

If yes, which one: ____

Treating physician: ________________________City & State ________________

Dates of Treatment: From: _______________ to: _________________________

Have you had any recent hospitalizations (within the last 12 months)? □ YES □ NO

If "yes", list dates and reasons: ____

____

____

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:

Do you have:

Ability to breathe on your own: □ YES □ NO
History of chest pain: □ YES □ NO
History of heart disease or any other heart/valve disorder: □ YES □ NO
Any chronic illness or condition: □ YES □ NO

If yes, please explain: ____

____

High Blood Pressure: □ YES □ NO
Low Blood Pressure: □ YES □ NO
Difficulty with physical exercise: □ YES □ NO
Osteoporosis: □ YES □ NO
Osteopenia: □ YES □ NO
History of fractures: □ YES □ NO

If yes, when and what bones: ____

____

Orders from your doctor not to exercise: □ YES □ NO
Recent surgery (Other than SCI in the last 12 months): □ YES □ NO

If yes, what and onset date: ____

____

Pregnancy (now or within the last 6 months): □ YES □ NO
Breathing/Lung Problems: □ YES □ NO
Asthma: □ YES □ NO
Any other disease of the lungs: □ YES □ NO
If yes, what and onset date: ______________________________

____

Muscle or joint condition: □ YES □ NO

Any previous injuries: □ YES □ NO

If yes, what and when: ______________________________

____

Were you ever treated by a doctor for this? ________ If yes, When? ______________________________

Diabetes: □ YES □ NO
If yes, Type 1 or Type 2 __________________
Thyroid condition: □ YES □ NO
If yes, what type? ________________________
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
Muscle Tone: □ YES □ NO
If yes, explain intensity and frequency ______________________________

____

Spasticity □ YES □ NO

If yes, explain intensity and frequency: ______________________________

____

Hardware (Rods, cages, etc): □ YES □ NO

If yes, please explain what, when and any complications: ______________________________

____

Hypersensitivity: □ YES □ NO

If yes, please explain: ______________________________

____

Orthostatic Hypotension (Low blood pressure): □ YES □ NO

If yes, please explain when you experience it and what your symptoms are: ______________________________

____

Heterotopic Ossification: □ YES □ NO

If yes, please explain: ____

____

Contracture: □ YES □ NO

If yes, please explain: ____

____

Cognitive impairments □ YES □ NO

If yes, please explain: ____

____

Thermoregulation Issues: □ YES □ NO

If yes, please explain your symptoms and preventative measures: ______________________

____

Pressure Sore(s): □ YES □ NO

If yes, please explain location, stage and status:______________________________

____

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: ____

____

Has your physician approved your participation in an 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: ____

____

Please answer the following questions completely and thoroughly:

List ALL assistive devices you use in everyday life, even if only for short periods (walker, type of wheelchair, AFO, Abdominal Binder, etc.):

____

____

____

Describe your physical abilities including controlled/uncontrolled movements, tone and/or spasms or joint issues. Be as specific as possible:

Upper Extremity (Shoulder, Arms, Hands, and Fingers): ____

____

Trunk (Back and Abdominals): ____

____

Lower Extremity (Hips, Legs, Feet, and Toes): ____

____

Please list ALL other physical challenges or special considerations (limits in range of motion, knee instability, joint/muscle disorder, other health issues): ____

____

____

Are you able to sit independently? □ YES □ NO

If no, describe the type and level of support you need:____

____

Are you able to stand independently? □ YES □ NO
Are you able to perform a sit-up independently? □ YES □ NO
Are you able to perform a seated trunk extension independently? □ YES □ NO
Are you able to take steps with assistance? □ YES □ NO

If yes, please describe the type of assistance needed: ____

____

Are you able to take steps independently? □ YES □ NO
Have you had a recent bone density assessment? □ YES □ NO

If yes, please attach a copy of the report with the doctor's interpretation.

NOTE: For safety reasons, clients with no bone density assessment or medical report of bone density assessment will be assumed to have osteoporosis. This may place limitations on the exercises used for your exercise program and prescription.

Please list all medications you are currently taking including the type, dosage and its function:

Medication	Dosage mg/day	Function

Please list your previous rehabilitation (physical therapy, occupational therapy, etc and location):

Where	Duration (Months)	Results:

List your current fitness/wellness regimen. Include any physical activity you do that would be considered exercise or rehab. (FES bike, Standing Frame):

Type	Duration (minutes/hours)	Frequency (How often?)