Moving with H.O.P.E.

Medical Statement
Client Record (Confidential Information)

This form must be completed in full and sent to:

MovingWithHOPE
Attn: Tad Duni
30 Controls Dr Shelton CT 06484
203-513-8424 fax 203-712-7320
tadduni@movingwithhope.org

NOTE: Completion of this form does not guarantee your participation in our program. All forms will be reviewed by the Director and Management to determine client participation. MovingWithHOPE and its representatives solely determine who is entered into the program and reserves the right to refuse service.

Personal and Contact Information **(All information must be completed in order to be submitted for a review process)**

Date: _____

Full Name: _____

Date of Birth (mm/dd/yy): _____ Age: _____

Address: _____

City: _____

State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Email **(Required)**: _____

In case of emergency, please notify:

Name: _____ Relationship: _____

Phone (home): _____ (work): _____ (cell): _____

Name: _____ Relationship: _____

Phone (home):_____(work):_____(cell):_____

Medical Information

Current Height: _____ Current Weight: _____ Sex: _____

Neurological Disorder (Check all that apply)

_____ SCI _____ TBI _____ MS

_____ Stroke _____ CP _____ Other: _____

If SCI, cause of injury: _____

Level of injury: _____

ASIA score: (at time of injury) _____ ASIA score: (current)_____

If MS, 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", then 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: _____

Advice from your doctor not to exercise: □ YES □ NO
Recent surgery (Other than SCI in the last 12 months): □ YES □ NO
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, joint or back disorder: □ YES □ NO
Any previous injuries: □ YES □ NO
If yes, what and when: _____
Were you ever treated by a Dr for this? When: _____

Diabetes: □ YES □ NO
Thyroid condition: □ YES □ NO
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 issues: _____

_____

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 (ie:, 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 (Arms, Hands, and Fingers):

Trunk (Back and Abdominals):

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

Please list *ALL* other physical challenges or special considerations (ie: limits in ROM, 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, all SCI clients MUST have a bone density assessment. It is also customary for all post-menopausal female to have a bpne density assessment.

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

Dosage mg/day Type (Function)

Please list your previous rehabilitation (physical therapy, occupational therapy, etc.)

Where	Duration (Months)	Results

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

Type	Duration (Minutes/Hours)	Frequency (How often)