



**6 North Corporate Drive
Riverdale, NJ 07457
Phone: 862-200-5848 - Fax: 862-200-5976**

Client Application

Date _____
Mm/dd/yyyy

Name _____
Last First Middle (complete)

Prefer to be called (nickname) _____ Gender _____
M/F

Birthdate _____ / _____ / _____ E-mail Address _____
mm/dd/yyyy

Permanent Home Address _____
Number and Street

City or Town State Country Zip Code

Permanent home phone (_____) _____
Area Code Number

Other phone (_____) _____
Area Code Number

Emergency contact

Name _____ Relationship _____
Last First

Home phone (_____) _____ Work/Cell phone(_____) _____
Area code Number Area code Number

How did you hear about Push to Walk? _____

Medical Information

Date of Injury _____/_____/_____
mm/dd/yyyy

ASIA Level/Score _____

At what hospital were you treated?

Name

Address

City State Zip Code

(_____) _____

Area Code Number

Treating physician _____
Name

Length of stay

from _____/_____/_____
mm/dd/yyyy

to _____/_____/_____
mm/dd/yyyy

Location of outpatient rehabilitation:

Name

Address

City State Zip Code

(_____) _____

Area Code Number

Dates of Attendance

from _____/_____/_____
mm/dd/yyyy

to _____/_____/_____
mm/dd/yyyy

Type of wheelchair Manual Electric _____
specify

Power Assisted/Manual

Assistive standing/walking device

Yes _____

No

Level of injury _____

Complete Incomplete

Location of inpatient rehabilitation:

Name

Address

City State Zip Code

(_____) _____

Area Code Number

Length of stay

from _____/_____/_____
mm/dd/yyyy

to _____/_____/_____
mm/dd/yyyy

Current therapy

Yes No

type _____ frequency _____

results _____

Surgeries since injury

Date *Type* *Location*

Date *Type* *Location*

Date of last medical examination _____ / _____ / _____
mm/dd/yyyy

Height _____

Weight _____

Please list all current medications

1 *Name* *Dose/Freq* *Function* *Start mo/yr*

2 *Name* *Dose/Freq* *Function* *Start mo/yr*

3 *Name* *Dose/Freq* *Function* *Start mo/yr*

4 *Name* *Dose/Freq* *Function* *Start mo/yr*

5 *Name* *Dose/Freq* *Function* *Start mo/yr*

6 *Name* *Dose/Freq* *Function* *Start mo/yr*

Describe your physical abilities (be as specific as possible):

Upper extremities

Trunk/core (IE: Can you sit up?)

Lower extremities

Any spasms? Yes No

If Yes, briefly explain locations

Any pain? Yes No

If Yes, briefly explain locations

Any Autonomic Dysreflexia? Yes No

If Yes, briefly explain symptoms

Any Pressure Sores/Skin Breakdowns? Yes No

If Yes, briefly explain symptoms

Any Heterotrophic Ossification? Yes No

Location

Have you been diagnosed with Osteoporosis? Yes No

How long ago was your bone scan?

NOTE: All clients over 6 months post injury must obtain a bone density assessment before their first session at Push To Walk. Please attach a recent bone density scan with your doctor's interpretation.

Deep Vein Thrombosis? Never Past Present

Location _____

Treatment _____

Ventilator Dependent? Never Past Present

Major illness/injuries/complications that required hospitalization other than initial injury?

Yes No

If Yes, explain:

What are your goals and / or health concerns for coming to Push To Walk?

Please circle 'yes' or 'no' for the following. Please answer 'yes' to those that apply to you at present or have applied to you in the past, with a brief explanation in the space provided.

Heart problems: yes / no

History of chest pain: yes / no

Blood pressure issues: yes / no

Diabetes: yes / no

Any chronic illness or condition: yes / no

Fatigue: yes / no

Muscle tension: yes / no

Tendon/joint problems: yes / no

Breathing/lung problems: yes / no

Cigarette smoker: yes / no *If yes, packs per day*

Alcohol: yes / no *Frequency*

High cholesterol: yes / no

Are you accustomed to physical exertion?

Hernia, or any condition that may be aggravated by intense exercise: yes / no

Any other disease or disorder that would cause difficulties while participating in an intensive exercise program?

Are you currently involved in any recreational physical activities (IE: handcycling, rugby, etc)?

Has your physician approved your participation in an intense exercise program? yes / no

NOTE: This is required prior to your first session at Push To Walk.

Is there any reason not mentioned here why you should not follow a regular exercise program? If yes, please explain: _____

Please make any other comments you feel are pertinent to your exercise program:

I have completed this application to the best of my knowledge. I understand that if necessary, Push To Walk reserves the right to request medical clearance before beginning any exercise program, and has the right to deny my participation in the program if requests are not fulfilled.

Please print your name clearly: _____

Signature: _____ **Date:** _____

If under 18, name of parent or guardian: _____ **Relationship:** _____

Parent or guardian's signature: _____ **Date:** _____

Thank you for taking the time to fill out Push To Walk's application.