SCI Recovery Project
Adaptive Exercise/Open Gym Application

In an effort to provide the most safe and effective program, it is necessary for all prospective clients of the Adaptive Exercise Program and Open Gym Program to complete this application in its entirety. 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:
E-mail: info@scirecoveryproject.org
Phone: (303) 286-0918
Fax: (303) 286-0946
Postal Address: SCI Recovery Project
866 East 78th Avenue
Denver, CO. 80229

An SCI Recovery Project team member will contact you upon receipt of your application.

Personal Contact:

Name (First, Last) :_____Date of Birth:___/___/_____
Home Phone: (_____)_____ Cell Phone:(_____)_____
Address: _____
City: _____ State: _____ Zip Code: _____
E-Mail: _____
Emergency Contact Name:_____
Emergency Contact Phone: (_____)_____ Relationship:_____

Personal Information:

Date of Injury:_____ Level of Injury: _____
Asia Score: _____ Incomplete or Complete: _____

How did you hear about SCI Recovery Project?
_____
_____

How were you injured?

_____
_____
_____

What hospital were you treated at?_____
Previous Rehabilitation: _____ How long:_____
Benefits of Rehab: _____
_____
_____

List any concerns you may have regarding specific exercises, limitations in range of motion, endurance levels, and/or experience in training. This information will help us advise you in your personal training plan:

_____
_____
_____
_____

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

_____
_____
_____
_____
_____
_____

Medical History Form

Name:	
Height:	**Weight:**
Gender: MALE / FEMALE	**Date of Injury:**
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:**

Please check YES or NO to the following:
NOTE: Indicate YES for all that apply at present or have applied to you 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, joint, or back disorder:	☐	☐
Diabetes:	☐	☐
Thyroid condition:	☐	☐
High cholesterol:	☐	☐
Obesity:	☐	☐
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:	☐	☐
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):	☐	☐
Urinary tract infection:	☐	☐
Catheter:	☐	☐
Bowel or bladder control:	☐	☐
Rods, plates, cages:	☐	☐
Do you smoke/use tobacco or tobacco products?	☐	☐
Do you drink alcoholic beverages?	☐	☐
Do you smoke/use marijuana or marijuana products?	☐	☐
Do you take any non-prescriptive supplements or medications?	☐	☐
Other:		

SENSORY AND MOTOR FUNCTION:	☑YES:	☑NO:
Do you have areas of normal sensation, not affected by your injury?	☐	☐
If yes, describe:		
Do you have areas of normal motor control, not affected by your injury?	☐	☐
If yes, describe:		

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:		
Are you currently taking any medications (including over the counter)?	☐	☐

If yes, list: **MEDICATION**	**DOSAGE/DAY**	**REASON**

Physician Release Form

The following needs to be filled out by your physician in order to give clearance to participate in our adaptive exercise programs. This helps reduce any risks, and it opens up communication between your physician and SCI Recovery Project.

Physician Name:	**Physician Address:**
Physician Phone: ( ) -	
Physician Specialty:	**Physician Fax: ( ) -**

Patient Name:		**Date of Birth:**	
Date of physical examination:		**Today's Date:**	
Recorded Vitals:	**HR:**	**BP:**	**Weight:**
	Height:	**Temp:**	**PO_2%:**

SCI Recovery Project offers one-on-one Adaptive Exercise and Open Gym programs that 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). If you have questions about our program, feel free to contact us at (303) 286-0918 or info@scirecoveryproject.org.

Please answer the following questions for the patient mentioned above:	☑YES:	☑NO:
This patient may participate fully in SCI Recovery Project programs without limitation.	☐	☐
This patient may participate in SCI Recovery Project programs with limitations or recommendations.	☐	☐
If yes, describe:		
Do any medical conditions affect client's ability to participate in SCI Recovery Project programs?	☐	☐
If yes, describe:		
Has a bone mineral density test been performed and evaluated by the physician?	☐	☐
If no, please describe why bone mineral density test was not deemed necessary:		
If yes, are results within normal range for age and gender?	☐	☐
If no, please describe variations and area(s) of concern:		

Patient Name:_____
Patient Signature: _____ Date _____

Physician Name: _____
Physician's Signature: _____ Date _____

Agreement and Release of Liability Form

1. In consideration of being allowed to participate in the activities and programs of SCI Recovery Project and to use its facilities, equipment and machinery, in addition to the payment of any fee or charge, I do hereby waive, release and forever discharge SCI Recovery Project and its directors, and employees from any and all responsibilities or liability from injuries or damages resulting from my participation in any activities or my use of equipment or machinery in the above mentioned activities. I do also hereby release all of those mentioned and any others acting upon their behalf from any responsibility or liability for any injury or damage to myself, including those caused by the negligent act or omission of any of those mentioned or others acting on their behalf or in any way arising out of or connected with my participation in any activities of SCI Recovery Project or the use of any equipment.
   IF YOU UNDERSTAND AND AGREE, INITIAL_____.

2. I understand and am aware that strength, flexibility and aerobic exercise, including the use of equipment, is a potentially hazardous activity. I also understand that fitness activities involve the risk of injury and even death, and that I am voluntarily participating in these activities and using equipment and machinery with knowledge of the dangers involved. I hear by agree to expressly assume and accept any and all risks of injury or death.
   IF YOU UNDERSTAND AND AGREE, INITIAL_____.

3. I do hereby further declare myself to be physically sound and suffering from no disease or illnesses that would prevent my participation or use of equipment or machinery except as hereinafter stated. I do hereby acknowledge that I have been informed of the need for a physician's approval for my participation in an exercise/fitness activity or in the use of exercise equipment and machinery. I also acknowledge that it has been recommended that I have a yearly or more frequent physical examination and consultation with my physician as to physical activity, exercise and use of exercise and training equipment so that I might have his/her recommendations concerning these fitness activities and equipment use. I acknowledge that I have either had a physical examination and have been given my physician's permission to participate or that I have decided to participate in activity and use of equipment and machinery without the approval of my physician and do hereby assume all responsibility for my participation and activities, and utilization of equipment and machinery in my activities.
   IF YOU UNDERSTAND AND AGREE, INITIAL_____.

4. I warrant and represent that I do not have any communicable disease, fungi or bacteria that could be transmitted by inhalation or absorption, and could therefore be detrimental to the health and safety of me, or other people at SCI Recovery Project. Such conditions include but are not limited to:

- Any sexually transmitted disease;
- Acquired Immunodeficiency Syndrome or Human Immunodeficiency Virus, or exposure to another having the same, or substances or materials contaminated with the same, or fear of contracting Acquired Immunodeficiency Syndrome, Human Immunodeficiency Virus, or any other communicable disease;
- Actual, alleged or threatened exposure to, consumption of, ingestion of, inhalation of, absorption of fungi or bacteria in any manner or form whatsoever;
- Actual or alleged presence of fungi or bacteria in any manner or form whatsoever.

IF YOU UNDERSTAND AND AGREE, INITIAL_____.

5. I agree to take responsibility for myself and to abide by the policy to IMMEDIATELY notify SCI Recovery Project if I have contracted any such communicable disease, fungi or bacteria, and understand that it is at the discretion of SCI Recovery Project staff, management, and/or board of directors to determine my continued participation in any program, should I have such communicable disease, fungi, or bacteria.
   IF YOU UNDERSTAND AND AGREE, INITIAL_____.

6. I understand that SCI Recovery Project agrees to provide an environment safe from, and warn of the dangers of communicable diseases, fungi, and bacteria. SCI Recovery Project agrees to do everything possible to prevent or suppress communicable diseases, fungi, or bacteria and their transmission between participants, staff, and volunteers. Should such a situation arise SCI Recovery Project agrees to report to the proper authorities, inform all participants, staff and volunteers, and reserves the right to suspend or terminate participation in programs or employment by SCI Recovery Project. SCI Recovery Project agrees to hiring, employment, training, and supervision of all staff and volunteers to ensure safety of all participants, staff, and volunteers.
   IF YOU UNDERSTAND AND AGREE, INITIAL_____.

To the extent that statute or case law does not prohibit releases for negligence, this release is also for negligence.

If any portion of this release from liability shall be deemed by a Court of competent jurisdiction to be invalid, then the remainder of this release from liability shall remain in full force and effect and the offending provision or provisions severed here from.

By signing this release, I acknowledge that I understand its content and that this release cannot be modified orally.

Printed Name _____
Signature:_____ Date _____

Honorable Agreement

I have read and completed this application to the best of my knowledge. I realize that it is in my best interest to complete these forms honestly. I understand that I need to inform SCI Recovery Project of any illnesses, disorders, or health issues that may not be specifically included on these forms. I will take full responsibility for any false responses to any of the questions in these forms, and do not hold SCI Recovery Project or it's staff to be liable for any omissions.

Printed Name: _____
Signature: _____ Date: _____

If under 18, or are unable to sign, please list name of Parent, Guardian or Power of Attorney:
_____ Relationship: _____

Parent, Guardian or Power of Attorney Signature: _____
Date: _____

**The information in this application is confidential and is protected under the Privacy Act. This information is used solely by the staff of SCI Recovery Project in determining program eligibility and participation.*