# SCI Recovery Project
# Integrative Therapies Application

In an effort to provide the most safe and effective program, it is necessary for all perspective clients of the Integrative Therapies 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.

**NOTE:** Our Integrative Therapies Program is only offered through the HCBS SCI Waiver. Participants **MUST** meet all required criteria of the pilot program, be Medicaid eligible, and be actively enrolled on the SCI Waiver by the State of Colorado Division of Health Care Policy and Finance. If you are not actively enrolled, but have questions about eligibility and enrollment, please contact:

| | |
|---|---|
| **Emily Moncrief MSW**<br>**SCI Waiver Specialist**<br>Community Living Office<br>1570 Grant Street,<br>Denver, CO 80203<br>PHONE: 303.866.4944<br>FAX: 303.866.2786<br>Emily.Moncrief@state.co.us | **Chanda Hinton Leichtle, MNM**<br>**Executive Director**<br>The Chanda Plan Foundation<br>866 East 78th Avenue<br>Denver, CO 80229<br>PHONE: 1.800.766.4255 x2<br>FAX: 1.800-533-4684<br>ch@iamtheplan.org |

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 the 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 that we should know about specific movements, limitations in range of motion. This information will help us advise you on your experience with us:

_____
_____
_____
_____

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

_____
_____
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## Medical History Form

| | |
|---|---|
| **Height:** | **Weight:** |
| **Gender:** MALE / FEMALE | **Date of Injury:** |
| **Primary Physician Name:** | **Physician Address:** |
| **Physician Phone: (  )  -** | |
| **Physician Specialty:** | **Physician Fax: (  )  -** |
| **Medicaid ID:** | **Other Insurance:** |
| **Case Management Agency:** | **Case Manager Name:** |
| **Agency Address:** | **Agency Phone: (  )  -** |
| | **Agency Fax: (  )  -** |
| **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, joing, or back disorder: | ☐ | ☐ |
| Diabetes: | ☐ | ☐ |
| Thyroid condition: | ☐ | ☐ |
| High cholesterol: | ☐ | ☐ |
| Obesity: | ☐ | ☐ |
| Hernia, or any condition that my 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? | ☐ | ☐ |

| **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 little/no sensation, severely affected by your injury? | ☐ | ☐ |
| If yes, describe: | | |
| Do you have areas of normal motor control, not affected by your injury? | ☐ | ☐ |
| If yes, describe: | | |

| | | |
|---|---|---|
| Do you have areas of abnormal motor control, 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: | | |
| Have you ever received acupuncture? | ☐ | ☐ |
| If yes, when was your last treatment, and what were your outcomes: | | |
| Have you ever received massage? | ☐ | ☐ |
| If yes, when was your last treatment, and what were your outcomes: | | |
| Have you ever received chiropractic care? | ☐ | ☐ |
| If yes, when was your last treatment, and what were your outcomes: | | |
| Do you have concerns about receiving any of the above-mentioned integrative treatments? | ☐ | ☐ |
| If yes, describe: | | |

| Are you currently taking any medications (including over the counter)? | ☐ | ☐ |
|---|---|---|
| If yes, list: **MEDICATION** | **DOSAGE/DAY** | **REASON** |
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## Agreement and Release of Liability Form

1. 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 the Spinal Cord Injury 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_____.

2. I agree to take responsibility for myself and to abide by the policy to IMMEDIATELY notify the Spinal Cord Injury Recovery Project if I have contracted any such communicable disease, fungi or bacteria, and understand that it is at the discretion of the Spinal Cord Injury Recovery Project staff,

management, and/or board of directors to determine my continued participation in any program, or continued employment should I have such communicable disease, fungi, or bacteria.
IF YOU UNDERSTAND AND AGREE, INITIAL_____.

3. I understand that the Spinal Cord Injury Recovery Project agrees to provide an environment safe from, and warn of the dangers of communicable diseases, fungi, and bacteria. The Spinal Cord Injury 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 Spinal Cord Injury 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 the Spinal Cord Injury Recovery Project. The Spinal Cord Injury 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 _____

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**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 include any illnesses, disorders, or health issues that may not be included on these forms. I will take full responsibility to any false responses to any of the questions in these forms, and do not hold it to SCI Recovery Project or it's staff to be liable.

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.*