Client Intake Form

- In an effort for Walk It Off Spinal Cord Wellness Centre Inc. (Walk It Off) to provide the most safe and effective programs, we require all clients to complete this application.
- The information on this form is confidential and will only be released with written consent by the client or if by order of the court or law.
- If your health status changes in the future, please let us know.
- Please complete the application and send it via fax or email to: Email: heather@walkitoffrecovery.org
- After your application is reviewed, our office will contact you by e-mail or phone. The completion of this application does not guarantee your participation in our program.

PERSONAL INFORMATION				
Name:		Date:		
Address:		City/Town:		
Province:		Postal Code:		
Telephone: (Home):		(Other Phone)		
Email (required): *NOTE: Because we may send our client's billing invoices via email, please put your billing email address above.*				
Weight:	Height:	Age:	Date of Birth:	☐ Male ☐ Female
Occupation:				
Recreational Activities:				
How did you hear about our facility?				
Primary Care Physician:		City:	Telephone:	

EMERGENCY CONTACT:	
Name:	Relationship:
Telephone: *(Home)*	*(Other Phone)*

DIAGNOSIS or REASON FOR SEEKING THERAPY:

SPINAL CORD INJURY (SCI) SPECIFIC HISTORY (if applicable)			
Diagnosis:	Level of Injury:	☐ Complete	☐ Incomplete
Date of Injury:	(yy /mm/dd)	☐ Motor Vehical Accident	
How were you injured:			
At which hospital were you treated?		City/Province:	
Treating Physician:	Late of last Medical Examination:		*(yy /mm/dd)*
Presence of internal pins, wires, rods, artificial joints and their locations:			

BONE DENSITY ASSESSMENT: *(Please attach a copy of the report with the doctor's interpretation.)*

Date of most recent bone density assessment: *(yy /mm/dd)*

Results: ☐ Normal Other:

NOTE:*All clients over 6 months post injury must obtain a bone density assessment with the doctor's interpretation.*

OTHER HEALTH CARE INVOLVEMENT:

Involved in other health care? (Physiotherapy, Massage Therapy, Chiropractic, Complimentary Therapy, Nutritionist, etc.):

Date Last Attended Rehabilitation: *(yy /mm/dd)*

Results:

HEALTH HISTORY (Please check the appropriate box to indicate that it applies to you at present or in the past.)

RESPIRATORY

- ☐ Shortness of breath
- ☐ Bronchitis
- ☐ Asthma
- ☐ Emphysema
- ☐ Smoking Packs/day:

INFECTIOUS DISEASE

- ☐ Hepatitis
- ☐ HIV/AIDS
- ☐ TB (Tuberculosis)
- ☐ Skin conditions

CARDIOVASCULAR

- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ CCHF
- ☐ Heart Attack
- ☐ Angina
- ☐ Chest pain
- ☐ Stroke/CVA
- ☐ Pacemaker
- ☐ Dizziness
- ☐ Heart Disease
- ☐ High Cholesterol
- ☐ Heart/Valve Disorder

OTHER CONDITIONS

- ☐ Diabetes ☐ Type1 ☐ Type 2
- ☐ Obesity
- ☐ Epilepsy
- ☐ Cancer
- ☐ Autonomic Dysreflexia
- ☐ Heterotropic Ossification
- ☐ Pathological Fractures
- ☐ Neurogenic Pain
- ☐ Pregnancy (present within last 3months

SOFT TISSUE / JOINT PAIN

Upper Back	☐ Right	☐ Left
Mid Back	☐ Right	☐ Left
Lower Back	☐ Right	☐ Left
Shoulders	☐ Right	☐ Left
Elbows	☐ Right	☐ Left
Wrists	☐ Right	☐ Left
Hands	☐ Right	☐ Left
Hips	☐ Right	☐ Left
Knees	☐ Right	☐ Left
Ankle	☐ Right	☐ Left
Feet	☐ Right	☐ Left

SUBLUXATION / DISLOCATION/ LIGAMENT LAXITY

Upper Back	☐ Right	☐ Left
Mid Back	☐ Right	☐ Left
Lower Back	☐ Right	☐ Left
Shoulders	☐ Right	☐ Left
Elbows	☐ Right	☐ Left
Wrists	☐ Right	☐ Left
Hands	☐ Right	☐ Left
Hips	☐ Right	☐ Left
Knees	☐ Right	☐ Left
Ankle	☐ Right	☐ Left
Feet	☐ Right	☐ Left

URO / GENITAL

- ☐ Intermittent Catheter
- ☐ Indwelling Catheter
- ☐ Surgical Bladder/Urethral
- ☐ Augmentation
  Type:
- ☐ Frequent UTIs (bladder infections)

DIGESTIVE/BOWEL

- ☐ Poor appetite
- ☐ Constipation
- ☐ Diarrhea
- ☐ Liver/Gallbladder prob
- ☐ Neurogenic Bowel
- ☐ Pain/Gas

Has you physician approved your participation in an intense exercise program? NOTE: *This is required prior to attend sessions at Walk It Off.*	☐ Yes	☐ No
Do you participate in regular physical activity?	☐ Yes	☐ No
Are you accustomed to vigorous activity?	☐ Yes	☐ No
Do you have regular eating habits?	☐ Yes	☐ No
Do you have good sleeping patterns?	☐ Yes	☐ No
Are you aware of any disease/disorder that would complicate your participation in an exercise program, other than the conditions indicated on the previous page?	☐ Yes	☐ No
If yes, please explain:		

MEDICATIONS:

Medication Type	***Dosage (mg)***	***Frequency***	***Type (Function)***

PAST SURGERY OR INJURY: (not SCI related)

Type	***Date***

PHYSICAL ABILITIES:

Being as specific as possible, describe your physical abilities and reactions to the following; be sure to include controlled movement, strength spasms, flaccidity and/or pain.

UPPER EXTREMITIES:

TRUNK: (ie Can you sit up?)

LOWER EXTREMITIES:

SENSORY STATUS

LEGEND:			***LEFT***				***RIGHT***			
F=Full P=Partial T=Trace N=None	LEGS	Proprioception	☐ F	☐ P	☐ T	☐ N	☐ F	☐ P	☐ T	☐ N
	ABOVE INJURY	Sweating	☐ F	☐ P	☐ T	☐ N	☐ F	☐ P	☐ T	☐ N
	BELOW INJURY	Sweating	☐ F	☐ P	☐ T	☐ N	☐ F	☐ P	☐ T	☐ N
			LEFT				***RIGHT***			
	SHOULDERS:	Pain	☐ F	☐ P	☐ T	☐ N	☐ F	☐ P	☐ T	☐ N
		Cold	☐ F	☐ P	☐ T	☐ N	☐ F	☐ P	☐ T	☐ N
		Hot	☐ F	☐ P	☐ T	☐ N	☐ F	☐ P	☐ T	☐ N
		Deep Touch	☐ F	☐ P	☐ T	☐ N	☐ F	☐ P	☐ T	☐ N
		Light Touch	☐ F	☐ P	☐ T	☐ N	☐ F	☐ P	☐ T	☐ N
		Burning	☐ F	☐ P	☐ T	☐ N	☐ F	☐ P	☐ T	☐ N
		Tingling	☐ F	☐ P	☐ T	☐ N	☐ F	☐ P	☐ T	☐ N
		Hypersensitivity	☐ F	☐ P	☐ T	☐ N	☐ F	☐ P	☐ T	☐ N
			LEFT				***RIGHT***			
	ARMS:	Pain	☐ F	☐ P	☐ T	☐ N	☐ F	☐ P	☐ T	☐ N
		Cold	☐ F	☐ P	☐ T	☐ N	☐ F	☐ P	☐ T	☐ N
		Hot	☐ F	☐ P	☐ T	☐ N	☐ F	☐ P	☐ T	☐ N
		Deep Touch	☐ F	☐ P	☐ T	☐ N	☐ F	☐ P	☐ T	☐ N
		Light Touch	☐ F	☐ P	☐ T	☐ N	☐ F	☐ P	☐ T	☐ N
		Burning	☐ F	☐ P	☐ T	☐ N	☐ F	☐ P	☐ T	☐ N
		Tingling	☐ F	☐ P	☐ T	☐ N	☐ F	☐ P	☐ T	☐ N
		Hypersensitivity	☐ F	☐ P	☐ T	☐ N	☐ F	☐ P	☐ T	☐ N

SENSORY STATUS contd

LEGEND:			***LEFT***				***RIGHT***			
F=Full **P=Partial** **T=Trace** **N=None**	HANDS:	Pain	☐ F	☐ P	☐ T	☐ N	☐ F	☐ P	☐ T	☐ N
		Cold	☐ F	☐ P	☐ T	☐ N	☐ F	☐ P	☐ T	☐ N
		Hot	☐ F	☐ P	☐ T	☐ N	☐ F	☐ P	☐ T	☐ N
		Deep Touch	☐ F	☐ P	☐ T	☐ N	☐ F	☐ P	☐ T	☐ N
		Light Touch	☐ F	☐ P	☐ T	☐ N	☐ F	☐ P	☐ T	☐ N
		Burning	☐ F	☐ P	☐ T	☐ N	☐ F	☐ P	☐ T	☐ N
		Tingling	☐ F	☐ P	☐ T	☐ N	☐ F	☐ P	☐ T	☐ N
		Hypersensitivity	☐ F	☐ P	☐ T	☐ N	☐ F	☐ P	☐ T	☐ N
			LEFT				***RIGHT***			
	LEGS:	Pain	☐ F	☐ P	☐ T	☐ N	☐ F	☐ P	☐ T	☐ N
		Cold	☐ F	☐ P	☐ T	☐ N	☐ F	☐ P	☐ T	☐ N
		Hot	☐ F	☐ P	☐ T	☐ N	☐ F	☐ P	☐ T	☐ N
		Deep Touch	☐ F	☐ P	☐ T	☐ N	☐ F	☐ P	☐ T	☐ N
		Light Touch	☐ F	☐ P	☐ T	☐ N	☐ F	☐ P	☐ T	☐ N
		Burning	☐ F	☐ P	☐ T	☐ N	☐ F	☐ P	☐ T	☐ N
		Tingling	☐ F	☐ P	☐ T	☐ N	☐ F	☐ P	☐ T	☐ N
		Hypersensitivity	☐ F	☐ P	☐ T	☐ N	☐ F	☐ P	☐ T	☐ N
			LEFT				***RIGHT***			
	FEET:	Pain	☐ F	☐ P	☐ T	☐ N	☐ F	☐ P	☐ T	☐ N
		Cold	☐ F	☐ P	☐ T	☐ N	☐ F	☐ P	☐ T	☐ N
		Hot	☐ F	☐ P	☐ T	☐ N	☐ F	☐ P	☐ T	☐ N
		Deep Touch	☐ F	☐ P	☐ T	☐ N	☐ F	☐ P	☐ T	☐ N
		Light Touch	☐ F	☐ P	☐ T	☐ N	☐ F	☐ P	☐ T	☐ N
		Burning	☐ F	☐ P	☐ T	☐ N	☐ F	☐ P	☐ T	☐ N
		Tingling	☐ F	☐ P	☐ T	☐ N	☐ F	☐ P	☐ T	☐ N
		Hypersensitivity	☐ F	☐ P	☐ T	☐ N	☐ F	☐ P	☐ T	☐ N
			LEFT				***RIGHT***			
	TRUNK:	Pain	☐ F	☐ P	☐ T	☐ N	☐ F	☐ P	☐ T	☐ N
		Cold	☐ F	☐ P	☐ T	☐ N	☐ F	☐ P	☐ T	☐ N
		Hot	☐ F	☐ P	☐ T	☐ N	☐ F	☐ P	☐ T	☐ N
		Deep Touch	☐ F	☐ P	☐ T	☐ N	☐ F	☐ P	☐ T	☐ N
		Light Touch	☐ F	☐ P	☐ T	☐ N	☐ F	☐ P	☐ T	☐ N
		Burning	☐ F	☐ P	☐ T	☐ N	☐ F	☐ P	☐ T	☐ N
		Tingling	☐ F	☐ P	☐ T	☐ N	☐ F	☐ P	☐ T	☐ N
		Hypersensitivity	☐ F	☐ P	☐ T	☐ N	☐ F	☐ P	☐ T	☐ N

GENERAL HEALTH AND WELLNESS: Please make any other comments you feel pertinent to your exercise program.