ADAPT ADVANCED

Upon completion, please fax to:
503.726.0599
Or mail to:
ADAPT Advanced
9923 SW Arctic Drive
Beaverton, OR 97005

Last Name ______________________

PERSONAL INFORMATION

Legal Name ______________________
Last First Middle

Program you are applying for: Trial Week Permanent Client Home Based Program

Date of Birth: ______________ Email Address: ______________

Permanent Home Address: ______________________
Number and Street

____
City *State* *Country* *Zip Code*

If different from above, please give your mailing address for all correspondence.

Mailing Address: ______________________
Number and Street

____
City *State* *Country* *Zip Code*

Primary Phone Number: ( ) ______ Cell Phone Number: ( ) ______

In Case of emergency, please notify:

Name: ______________ Relationship: ______________

Contact Phone Number: ( ) ______ Alternate Phone Number: ( ) ______

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MEDICAL INFORMATION

Disability: ______________________________

Nature of Disability: ______________________________

Date of Injury: ______________ Level of Injury: ______________

Complete Incomplete Asia Score: ________ Hardware (Level): ________

Cause of Injury: ______________________________

Height: ______________ Weight: ______________

Are you currently participating in therapy: Yes No

If Yes, where: ______________________________

Type/frequency of therapy: ______________________________

Mode of Ambulation

Wheelchair: Manual Chair Power Chair Power Assisted Manual Chair

Assistive standing/walking device:

Briefly describe type of device used and ability: ______________________________

Hospitalization(s) since injury

Date	Reason	Location
Date	Reason	Location
Date	Reason	Location

Hospitalization of initial trauma ______________ Name of Facility

Location of rehabilitation ______________ Name of Facility

Duration of Stay: ______________ Duration of Stay: ______________

Please list all current medications

1. ____

Name	*Dose*	*Frequency*	*Start month/year*

2. ____

Name	*Dose*	*Frequency*	*Start month/year*

3. ____

Name	*Dose*	*Frequency*	*Start month/year*

4. ____

Name	*Dose*	*Frequency*	*Start month/year*

5. ____

Name	*Dose*	*Frequency*	*Start month/year*

6. ____

Name	*Dose*	*Frequency*	*Start month/year*

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.

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
High blood pressure:	Yes	No
Low blood pressure:	Yes	No
Difficulty with physical exercise:	Yes	No
History of pathological fracture:	Yes	No
Pregnancy:	Yes	No
Breathing/Lung Problems:	Yes	No
Asthma:	Yes	No
Do you smoke? If yes, how often: ____________________	Yes	No
Any other disease of the lungs:	Yes	No
Diabetes:	Yes	No
Thyroid condition:	Yes	No
High cholesterol:	Yes	No
Obesity:	Yes	No
Hernia or any condition that may be aggravated by intense exercise:	Yes	No
Muscle, joint or back disorder, or previous injury still affecting you:	Yes	No

If yes, please explain: ____

____

____

Has your doctor cleared you to participate in an intense exercise program? Yes No

***A physician's release is required to participate with ADAPT Advanced, LLC.**

***Please initial if you understand this policy:** ____________

Sensory and Motor Conditions

Briefly describe areas that have *normal* sensation below level of injury: ____________

____

____

Briefly describe areas that have *little to no* sensation below level of injury: ____________

____

____

Briefly describe muscles that have *normal* movement below level of injury: ____________

____

____

Briefly describe muscles that have weakness to no movement below level of injury: ____________

____

Do you experience any spasms? Yes No

If Yes, briefly explain ____________________________________

____

Do you experience any pain? Yes No

If Yes, briefly explain ____________________________________

____

Do you experience Autonomic Dysreflexia (AD)? Yes No

If Yes, briefly explain symptoms ____________________________

____

Do you have a history of Urinary Tract Infections (UTI)? Yes No

Date of most recent ____________________

Do you have a history of pressure sores/skin breakdowns? Yes No

If Yes, briefly explain what area ____________________________

____

***Please know that it is your responsibility to notify ADAPT Advanced of any skin irritation/possible pressure sores.**

***Please initial if you understand this policy** ____________

Do you have Heterotrophic Ossification (H.O.)? Yes No

If Yes, location of H.O. ____________________________________

____

Have you been diagnosed with Osteoporosis/Osteopenia? Yes No

***ADAPT Advanced requires you to obtain a bone density scan if you are more than one year post injury, and it must have been done within the last 6 months.**

***Please initial if you understand this policy** ___________

Have you experienced Deep Vein Thrombosis? Never Past Present

Do you have bladder/bowel control? Yes No

If Yes, briefly describe ____

____

What are your goals and/or health concerns for participating with ADAPT Advanced? __________

____

____

____

What experiences have you had with alternative medicine (acupuncture, massage, etc.)? _______

____

____

____

Qualifications

To become a client of ADAPT Advanced, you must meet the following criteria:

Neurological Disorder at any level as long as the individual can breath without the use of a machine.

Cleared by a physician to participate in an intense exercise therapy program.

Cleared by a physician to perform weight-bearing activities through the upper and lower extremities (a bone density scan will be required for those 1 or more years post-injury).

I have completed this application to the best of my knowledge in an effort to make known any medical conditions that may limit my participation in ADAPT Advanced. I further understand that ADAPT Advnaced has the right to terminate my program at any time.

______________________________ ______________________

Signature *Date*