Member Information

Welcome to The Empowerment Neurofitness and Wellness Center. We are pleased to welcome you into our program.

Date ____/____/____

Name _____ DOB _____/_____/_____

Address _____

City _____ Zip Code _____

Home phone _____Cell phone _____

Business Phone _____Email _____

How did you hear about us? (circle)? Referral / Media/Website/Other_____

Primary Care Physician/Phone

_____

Neurologist/Phone

_____

Emergency Contact Information

Name _____ Phone:_____

Relationship to applicant_____

Address _____

City _____ Zip Code _____

Media Release

I _____ (member name) allow Empowerment! Wellness to publish or broadcast my image/likeness and/or name for promotional purposes associated with Empowerment! Wellness.

Signature _____Date _____

Health/Medical Questionnaire:

Present/Past

Check if you had or if you presently have any of the following:

Rheumatic fever: _____

Recent operation_____

Edema (swelling of ankles) _____

High blood pressure_____

Low blood pressure_____

Injury to back or knees_____

Seizures_____

Lung disease_____

Heart attack or know heart disease_____

Fainting or dizziness_____

Diabetes_____

High Cholesterol_____

Orthopnea (the need to sit up to breathe comfortably) _____

Shortness of breath_____

Chest pains_____

Palpitations or tachycardia (unusually strong or rapid beat) _____

Intermittent claudication (calf cramping) _____

Pain, discomfort in the chest, neck, jaw, arms, or other areas_____

Know heart murmur_____

Unusual fatigue or shortness of breath with usual activities_____

Temporary loss of visual acuity or speech, or short-term numbness or weakness in one side, arm, or leg of your body_____

Stroke_____

Parkinson's Disease_____

Multiple Sclerosis _____

Cancer_____

Other (please describe) _____

Family History

Have any of your first-degree relatives (parent, sibling, or child) experienced the following conditions? In addition, please identify at what age the condition occurred.

Heart attack

Heart operation

Congenital heart disease

High blood pressure

High cholesterol

Diabetes

Other:

Activity History

Do you participate in a regular exercise program at this time?

Can you currently walk 4 miles briskly without fatigue?

Have you ever performed resistance training in the past?

Do you have injuries (bone or muscle that would interfere with exercising?

Do you smoke? _____ If yes, how much per day and what was the age that you started?

Do you follow or have you recently followed any specific dietary intake plan and how do you feel about your nutritional habits in general?

What are your general fitness objectives?

List the medications that you are currently taking

Parkinson's Information:

Estimated date of diagnosis ____/____/____

Which symptoms are you experiencing? (check all that apply)

- ☐ Tremors - if yes, which side is most affected? ☐ RIGHT ☐ LEFT ☐BOTH
- ☐ Postural changes
- ☐ Loss of balance in the last year
- ☐ Slowness of movement
- ☐ Vision impairment
- ☐ Difficultly concentrating or staying focused
- ☐ Fatigue
- ☐ Depression

Other Health Questions

Do you: (check all that apply)

- ☐ Use a walker, wheelchair or other assistive device
- ☐ Have Deep Brain Stimulation (DBS)
- ☐ Feel dizzy or unsteady with sudden movements

☐ Have difficulty getting down or rising from a seated or lying position

What symptoms of Parkinson's are you experiencing in your daily life?

_____

_____

Have you been diagnosed with any other medical problems we should be aware of?

_____

_____

What do you wish to gain from joining Rock Steady Boxing?

_____

_____

Do you have questions or concerns about the program before we get started?

Additional administrator notes: _____

_____

_____

Multiple Sclerosis:

Primary diagnosis: (circle one) Relapse-Remitting OR Progressive

Date of diagnosis ____/____/____

Date of last relapse: ____/____/____

Type of MS: (circle) Relapse-Remitting, Secondary Progressive, Primary Progressive, Progressive Relapsing

Primary Symptoms (brief description)

Balance_____

Weakness/Difficulty Moving Limbs _____

Vision Impairment _____

Speech/Swallowing _____

Fatigue _____

Rigid/Tight Muscles_____

Tremor_____

Numbness or Loss of Sensation_____

Bowel/Bladder_____

Memory_____

Vision_____

Have you lost your balance or fallen in the past year (circle one)? Yes No

If yes, **how many have you had in the past 3 months** and explain when and where they happened:_____
_____

Stroke:

Date of diagnosis ____/____/____

Type of Stroke: (circle) transient ischemic attack, ischemic stroke, and hemorrhagic stroke

Primary Symptoms (brief description)

Hemiparesis: Left or Right_____

Weakness _____

Vision Impairment _____

Shortness of breath _____

Fatigue _____

Aphasia _____

Other _____