ReYu Paralysis Recovery Centre
Client Application Form

In an effort to provide the most safe and effective programs, ReYu Paralysis Recovery Centre requires all clients to complete this application in its entirety. All information provided will remain confidential. If the client is under the age of 18, a parent or guardian must sign the application.

Upon completion, please scan and email to:

nancy@reyu.ca

After your application is reviewed, we will contact you by e-mail or phone. The completion of this application does not guarantee your participation in our program.

Personal Information

Name: _____ Birthday (dd/mm/year):_____/_____/_____

Address:_____

City: _____Province: _____ Postal Code: _____

Home Phone: _____Cell Phone: _____

Email (Required): _____

In case of Emergency, please notify:

Name:_____ Relationship:_____

Phone:_____ Alternate Phone: _____

If different from above please give your mailing address for future correspondence OR for client's under the age of 18 please provide parent or guardian information:

Name: _____

Address:_____

City: _____Province: _____ Postal Code: _____

Home Phone: _____Cell Phone: _____

Email (Required):_____

Medical Information Height _____ Weight_____ Date of Onset_____ /____ /_____
dd/mm/yyyy

Neurological Condition/ Diagnosis: (Check all that apply)

☐Aquired Brain Injury ☐Cerebral Palsy ☐Multiple Sclerosis ☐Spina Bifida ☐Spinal Cord Injury

☐Transverse Myelitis ☐Spinal Tumor ☐Stroke☐Other:(please describe)_____

_____

If Cerebral Palsy, what type?_____

If Spinal Cord Injury, Aquired Brain Injury or Spinal Tumor: What was the cause of Injury?

_____

Level of Injury _____ ☐Complete ☐Incomplete Asia Level/Score_____

Rehabilitation hospital stayed at? _____ Province:_____

Current Physiatrist: _____Date of Last Medical Examination:____/_____
mm/yyyy

Any surgical hardware/ implants (rods, screws, plates, shunts, etc):

☐ No

☐ Yes, please indicate type and location:_____

Please note: ReYu encourages all Clients to maintain a healthy weight. For the safety of our staff, certain programs have restricted access based on height-weight parameters.

Please list the type, dosage, frequency and function of <u>all</u> medications you are taking:

	Name	*Dose*	*Freq*	*Start mo/yr*
1				
2				
3				
4				
5				
6				
7				

Please answer <u>Yes</u> or <u>No</u> to the following. Indicate "<u>Yes</u>" 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
Pacemaker: ☐ 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 (now or within the last 3 months): ☐ Yes ☐ No
Asthma: ☐ Yes ☐ No
Any other disease/problems of the lungs: ☐ Yes ☐ No
Diabetes: ☐ Yes ☐ No
Thyroid condition: ☐ Yes ☐ No
High Cholesterol: ☐ Yes ☐ No
Cigarette smoking, chew, or nicotine patch: ☐ Yes ☐ No
Obesity: ☐ Yes ☐ No
Hernia, or any condition that may be aggravated by intense exercise: ☐ Yes ☐ No
_____

Muscle, joint or back disorder, or any previous injury still affecting you: ☐ Yes ☐ No
If yes, please explain:_____
_____

Any chronic illness or condition:_____ ☐ Yes ☐ No
Has your doctor cleared you to participate in an intense exercise program? ☐ Yes ☐ No
Recent surgery in the last 12 months:_____ ☐ Yes ☐ No
Are you aware of any disease or condition that would complicate your participation in an exercise program, other than those you have checked above? ☐ Yes ☐ No
If yes, please explain:_____
_____

A physican's clearance is required to participate in ReYu Paralysis Recovery Centre Programs.

Please initial if you understand this policy_____

Assistive devices used throughout your week: (Check all that apply)

☐Wheelchair (electric) ☐Wheelchair (manual) ☐Scooter ☐Walker (4 wheeled) ☐Walker (2 or no wheels)

☐Crutches ☐Cane ☐Orthoses(AFO) ☐Orthoses (KAFO) ☐Orthoses (wrist/hand) ☐Clamshell back brace
☐Other devices used please list:_____

Hospitalization of initial onset (if any)

_____
Name

_____
Address

_____
City, Province

Length of Stay
From: _____/_____/_____
dd/mm/yyyy
To: _____/_____/_____
dd/mm/yyyy

Location of Rehabilitation (if any)

_____
Name

_____
Address

_____
City, Province

Length of Stay
From: _____/_____/_____
dd/mm/yyyy
To: _____/_____/_____
dd/mm/yyyy

Hospitalization since Injury

Date	Reason	Location
Date	Reason	Location
Date	Reason	Location
Date	Reason	Location

Sensory and Motor Condition Presentation. Be as specific as possible.

Briefly describe areas of the body that have *altered, little, or no* **sensation**, or areas affected by your condition

_____
_____
_____
_____

Briefly describe the areas of the body that have *little or no* **motor control**, or are severely affected by your condition

_____
_____
_____
_____

Briefly describe any spasticity (location, type, duration, triggers).

_____
_____
_____

Briefly describe any tone (location, type, duration, triggers).

_____
_____
_____

Do you have pain? ☐ Yes ☐ No

If Yes, briefly explain, state location(s), patterns and specify neuropathic or not

_____
_____
_____
_____

Do you have Autonomic Dysreflexia? ☐ Yes ☐ No
If Yes, briefly explain symptoms and state most recent attack

_____
_____
_____
_____

Do you have a history of Urinary Tract Infections? ☐ Yes ☐ No
If Yes, briefly explain symptoms and list the most recent one

_____
_____
_____
_____

Do you have a history of Skin breakdown/ Pressure sores? ☐ Yes ☐ No
If Yes, briefly explain the cause and location

_____
_____
_____
_____

Please understand that it is your responsibility to notify ReYu Paralysis Recovery Centre of any skin irritations/ possible pressure sores.
Please initial if you understand this policy_____

Do you have Heterotrophic Ossification? ☐ Yes ☐ No
Location

_____

Have you had a Deep Vein Thrombosis? ☐ Never ☐ Past ☐ Present

Are you on blood thinners? ☐ Yes ☐ No

Do you have Bladder control? ☐ Yes ☐ No

Do you have Bowel control? ☐ Yes ☐ No

Have you been diagnosed with Osteoporosis/Osteopenia? ☐ Yes ☐ No
Have you had a recent bone density assessment/scan? ☐ Yes ☐ No

If so, please attach a copy of the report with the doctor's interpretation.
Results: Normal _____ Other: _____

****All Clients* over 6 months post injury must obtain a bone density assessment and are required to submit a copy of the bone density report *with the doctor's interpretation* before their first session at ReYu Paralysis Recovery Centre. *We do not interpret bone density reports*. Clients must update bone density assessment annually.***

****Please initial if you understand this policy_____***

What therapies or treatments have you tried in the past and discontinued (what and why)?
(ie. acupuncture, massage, stem cells, etc)

_____
_____
_____
_____

Other therapies/activities currently ongoing?
(ie. massage, physiotherapy, FES, OT, Speech therapy, parasport, etc)

_____
_____
_____
_____

Anything else we should be aware of such as catheter locations, pumps, GI tubes, trachs, etc?

_____
_____
_____
_____

What are your goals and / or health concerns for coming to ReYu Paralysis Recovery Centre?

_____
_____
_____
_____

How did you hear about ReYu?

☐ Family/ Friends ☐ Facebook ☐ Internet/ website ☐ Referral ☐ Other:_____

I have completed this application to the best of my knowledge in order to make known any diagnosed medical problems or characteristics that may increase the risk of health problems, signs or symptoms indicative of health problems and lifestyle behaviors related to positive or negative health, which will enable ReYu Paralysis Recovery Centre to determine if medical clearance is needed before beginning an exercise program. I understand that if necessary, ReYu Paralysis Recovery Centre reserves the right to request medical clearance which may involve a bone scan and physician's evaluation and approval before beginning any exercise program, and has the right to deny my participation in the program if requests are not fulfilled and has the right to terminate my program at any time.

Please print your name clearly: _____

Signature: _____ Date: _____

If under 18, name of parent or guardian: _____ Relationship: _____

Parent or guardian's signature: _____ Date: _____