Challenge CENTER

Client Name: _____

Date: _____

Address: _____

City: _____ State: _____ Zip code: _____

Gender: □ Male □ Female Date of Birth: _____ Email: _____

Primary Phone Number: _____ □ Home □ Work □ Cell □ Use this number for scheduling

Alternate Phone Number: _____ □ Home□ Work □ Cell □ Use this number for scheduling

Emergency Contact: _____ Relationship: _____ Phone Number: _____

What Challenge Center services are you interested in?

□ Physical Therapy
□ Assisted Fitness
□ Supervised Fitness
□ Caregiver Family (Keep-Fit)
□ Aquatics Group Exercise
□ Balance Class
□ Pre- Exercise Screening
□ CFES Program/Training
□ Caregiver Training
□ Wheelchair Fitting
□ I'm not sure

Who can we thank for referring you to Challenge Center? _____ _____

What is your primary diagnosis? _____

Other diagnosis(es): _____

Primary Insurance Provider: _____ Secondary Provider: _____

Primary Physician (please list full name if known): _____Fax # _____

Medical Group/Hospital Affiliation: _____ Phone Number: _____

Medical History: Please check all conditions that you currently have, or have had:

□ High blood pressure/Hypertension
□ Low blood pressure
□ Chest pain / Angina
□ Heart attack
□ Heart surgery
□ Cardiac Arrhythmia
□ Coronary Artery Disease
□ Peripheral Vascular Disease
□ Chronic Venous Thromboemolic Disorder
□ Chronic Heart Failure
□ Apastic aneima
□ Hemophilia
□ Immune thrombocytopenic purpura
□ Myelodysplatic syndrome
□ Sickle-cell disease (excluding sickle-cell trait)
□ Angioplasty
□ Palpitation / arrhythmia
□ Heart disease
□ Other cardiovascular condition
□ Other arterial or venous surgery
□ Dementia
□ Diabetics Mellitus
□ End-stage Liver Disease
□ Pulmonary Embolism
□ Deep Vein Thrombosis
□ Pacemaker
□ Chronic Alcohol or other Drug Dependence
□ Rheumatoid Arthritis, Lupus, Polyarteritis nodosa, Polymyalgia rheumatic or Polymyositis
□ Stroke
□ HIV/AIDS
□ Cancer
□ Obesity
□ Blood disorder
□ Rash
□ Seizures / Epilepsy
□ Fainting / blackouts
□ Autoimmune disorder
□ Autonomic Dysreflexia
□ Infection: viral or bacterial
□ GERD
□ Gastrointestinal disease

□ Kidney disease
□ End-stage renal disease requiring dialysis
□ Asthma
□ COPD
□ Chronic Bronchitis
□ Emphysema
□ Pulmonary Fibrosis
□ Pulmonary Hypertension
□ Other lung disease
□ Other organ disease
□ Organ surgery
□ Diabetes
□ Osteopenia / -porosis /fracture
□ High cholesterol
□ Arthritis
□ Depression/anxiety/mood disorder
□ Bipolar Disorder, Major Depressive Disorder, Paranoid Disorder, Schizophrenia Schizoaffective Disorder
□ Amyotrophic Lateral Sclerosis (ALS)
□ Extensive paralysis (i.e., hemiplegia, quadriplegia, paraplegia, monoplegia)
□ Huntington's Disease
□ Multiple Sclerosis
□ Parkinson's Disease
□ Polyneuropathy
□ Spinal Stenosis
□ Spinal Cord Injury
□ Stroke-related neurologic deficit
□ Other

Other: If there are any conditions you have had or still have that are not listed above, please list them here:

_____

_____

Allergies: please list all known: _____

Surgical History (type and date): _____ Date: _____

_____ Date: _____

_____ Date: _____

Other Hospitalization(s) Reason: _____ Date: _____

Reason: _____ Date: _____

Reason: _____ Date: _____

Previous Rehabilitation received (dates and facility):

Facility: _____ Date: _____ to _____

Facility: _____ Date: _____ to _____

Facility: _____ Date: _____ to _____

Medications: Include all over-the-counter and prescription medications (Please write clearly)

1. _____ taken _____ times a day/week treating _____
2. _____ taken _____ times a day/week treating _____
3. _____ taken _____ times a day/week treating _____
4. _____ taken _____ times a day/week treating _____
5. _____ taken _____ times a day/week treating _____

Symptoms: Please check all that you are currently experiencing, or have recently experienced:

- □ Visual disturbance (blindness, double vision, etc.)
- □ Hearing loss
- □ Fatigue
- □ Abnormal sensation
- □ Swelling
- □ Abnormal bleeding
- □ Balance Problems / Falls
- □ Shortness of breath
- □ Incontinence / bowel or bladder problems
- □ Fever / chills / night sweats
- □ Sudden Weight loss or gain
- □ Headaches
- □ Dizziness
- □ Confusion / memory loss
- □ Other (please describe)-

_____

Pain: please answer the following regarding any pain you are having or have recently had:

Location(s):_____ Intensity 0 (no pain) - 10 (worst pain imaginable): _____

Type of pain (please check any that apply): □ Constant □ Intermittent □ Burning □ Aching □Sharp □ Dull

Location(s): _____ Intensity 0 (no pain) - 10 (worst pain imaginable): _____

Type of pain (please check any that apply): □ Constant □ Intermittent □ Burning □ Aching □Sharp □ Dull

Other: _____ Intensity 0 (no pain) - 10 (worst pain imaginable): _____

Type of pain (please check any that apply): □ Constant □ Intermittent □ Burning □ Aching □Sharp □ Dull

Physical impairments: Please list any/all you currently have:

- □ High or Low Tone
- □ Poor Coordination
- □ Ataxia
- □ Hemiplegia
- □ Paralysis
- □ Limb Loss
- □ Weakness
- □ Shortness of breath
- □ Angina
- □ Arrhythmia
- □ Poor endurance
- □ Numbness
- □ Contracture

Activities of Daily Living: Please mark the activities that your physical impairment substantially limits or prevents you from accomplishing i.e. which activities can you **NOT** do without the assistance of another person? Please also circle any activities that you never did before your incident.

- □ Toileting
- □ Bathing/Showering
- □ Eating
- □ Dressing
- □ Transferring (i.e. bed to chair or wheelchair to toilet)
- □ Walking
- □ Cooking
- □ Housekeeping
- □ Shopping
- □ Laundry
- □ Using the phone
- □ Taking Medication
- □ Budgeting
- □ Feeding Yourself
- □ Sitting Up
- □ Standing
- □ Lifting 3 lbs.
- □ Reaching
- □ Climb stairs with a railing
- □ Climb stairs without a railing
- □ Stepping up/down curbs

What devices do you use to move about?

- □ Wheelchair
- □ Cane
- □ 4 point cane/Hemi-cane
- □ Crutches
- □ Walker
- □ 4 Wheel Walker
- □ Platform Walker
- □ Other (please describe)

_____

How many feet or blocks can you walk using any assistive device needed (cane, 4 point cane, crutches, walker etc.)?
_____ feet/blocks (please circle)

Do you need help from another person to walk? □ Yes □ No How much assistance do they provide? _____ %

Can you manage stairs? □ Yes □ No Steps? □ Yes □ No Curbs? □ Yes □ No

Which impairment most limits your walking, if any? _____

Please share any other relevant information we may have missed regarding your abilities or disabilities:

_____

_____

What could you do before that you cannot do now? _____

What would you like to be able to do that you cannot do now? _____

_____

What are the major goals you would like to achieve here at Challenge Center? _____

_____

Are you receiving PT, OT, or ST at another facility? □ Yes □ No

If yes, which facility? _____ How often? _____ times a week/month

Do you receive assistance from another person in your daily life? □Yes □No

If yes, how many hours per day? _____ Days per week? _____ Who assists you? _____

CAREGIVER TRAINING

If you have a caregiver/friend/family member that assists you with daily activities, please have them fill this out, or fill it out with them

Does your caregiver feel they are at risk for a back injury because of the tasks you perform as a caregiver? □Yes □No

Has your caregiver been trained in good body mechanics while performing your caregiving tasks (e.g. transfers, bed mobility, bathing, etc.)? □ Yes □No □N/A

Would you like us to provide training for you regarding your role as a caregiver? □Yes □No

What can we help you with regarding caring for and assisting your client or loved one?

_____

_____

Please provide any additional information you would like us to know, or any questions or concerns you may have:

_____

_____