CLIENT INFORMATION FORM

Please fill out the following completely and accurately.

Date: _____

CLIENT WITH NEUROLOGICAL MOBILITY CONDITION

Name: _____

Age: _____ Date of Birth: _____/_____/_____

Address: _____

_____

Cell Phone: _____

Email Address: _____

Disability/Diagnosis: _____

_____

Disability/Diagnosis Details: _____

_____

_____

Height: _____ Weight: _____lbs.

Primary Language Spoken/Understood: _____

PARENT/GUARDIAN INFORMATION

(Necessary for clients under 18 years of age)

Name: _____

Relation: _____

Address: _____

Cell/Work Phone: _____

Email Address: _____

Primary Language Spoken/Understood: _____

EMERGENCY CONTACT INFORMATION

(if different from Parent/Guardian)

Name: _____

Relation: _____

Cell Phone: _____

Work Phone: _____

Primary Language Spoken/Understood: _____

PHYSICIAN INFORMATION

Name: _____ Name of Facility: _____

Office Phone: _____ Location (City/State): _____

To be completed by the client or parent/guardian - please answer all questions that pertain to the client.

Have you sustained a spinal cord injury? ☐ Yes ☐ No

Level of SCI: _____ Cause of SCI: _____ Date of SCI: _____

Surgery date and procedure: _____

If you experience autonomic dysreflexia, do you know when it's happening? _____

Please describe usual presentation and trigger: _____

_____

Have you sustained a traumatic brain injury? ☐ Yes ☐ No

If yes, please describe _____

Are you able to walk? ☐ Yes ☐ No

If yes, do you use braces? ☐ Yes ☐ No

What type of assistive device do you use (I.e., crutches, walker, AFO, KAFOs)? _____

What are your primary means of mobility (i.e., power chair, manual wheelchair, cane, walker)? _____

Do you need assistance with any transfers to and from your wheelchair? ☐ Yes ☐ No

If yes, how much assistance do you need: _____

Have you ever had a bone density scan/DEXA scan? ☐ Yes ☐ No

If yes, when and what were the results: _____

Have you ever been diagnosed with osteopenia or osteoporosis? ☐ Yes ☐ No

Have you had any seizures in the last two years? Please Describe: _____

Do you have scoliosis? ☐ Yes ☐ No

Do you have heterotropic ossification or history of H.O.? ☐ Yes ☐ No

Do you have pain? ☐ Yes ☐ No Please describe if so: _____

Do you have a catheter, feeding tube, baclofen pump or other devices? (i.e. deep brain stimulator, etc.) ☐ Yes ☐ No

If yes, please describe: _____

Please list any other past medical history, surgeries, etc.: _____

_____

Are you taking any medications: ☐ Yes ☐ No

Please List All Medications:

1. _____
2. _____
3. _____
4. _____
5. _____

How long has it been since you stood upright: _____

Do you ever get lightheaded or dizzy when you stand: ☐ Yes ☐ No

Do you have a standing frame: ☐ Yes ☐ No

If so, how often and for how long do you use it? _____

Do you currently have any open wounds (pressure sores, abrasions, cuts, etc.) or a history of wounds? ☐ Yes ☐ No

If yes, where and/or where? _____

What is your living situation? _____

Do you have a visual impairment? ☐ Yes ☐ No Do you have a hearing impairment? ☐ Yes ☐ No

Do you have or have had anxiety, depression, or aggression? ☐ Yes ☐ No

If yes, please describe: _____

Client's Name (Please Print): _____

Client's Signature: _____ Date: _____

Parent/Guardian Name (Please Print): _____

Parent/Guardian Signature: _____ Date: _____