

**Medical Statement
Client Record (Confidential Information)**

This form must be completed in full and sent to:

NextStep Fitness, Inc.
Attn: Jill Yi
Business Manager
4447 Redondo Beach Blvd
Lawndale, CA 90260
Fax: (310) 542-8868
Email: jilly@nextstepfitness.org

NOTE: Completion of this form does not guarantee your participation in our program. All forms will be reviewed by the Director and Management to determine client participation. NextStep Fitness, Inc. and its representatives solely determine who is entered into the program and reserves the right to refuse service.

Personal and Contact Information (All information must be completed in order to be submitted for a review process)

Date: _____

Full Name: _____

Date of Birth (mm/dd/yy): _____ Age: _____

Address: _____

City: _____

State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Email (Required): _____

In case of emergency, please notify:

Name: _____ Relationship: _____

Phone (home): _____ (work): _____ (cell): _____

Name: _____ Relationship: _____

Phone (home): _____ (work): _____ (cell): _____

Medical Information

Current Height: _____ Current Weight: _____ Sex: _____

Neurological Disorder (Check all that apply)

_____ SCI _____ TBI _____ MS
_____ Stroke _____ CP _____ Other: _____

If SCI, cause of injury: _____

Level of injury: _____

ASIA score: (at time of injury) _____ ASIA score: (current) _____

If MS, what type? _____

Date of Injury/Diagnosis: _____

Hospital where initially treated: _____

Treating physician: _____ City & State _____

Dates of Stay: From: _____ to: _____

Did you attend a rehabilitation hospital that specializes in your injury?: YES NO

If yes, which one: _____

Treating physician: _____ City & State _____

Dates of Treatment: From: _____ to: _____

Have you had any recent hospitalizations (within the last 12 months)? YES NO

If "yes", then list dates and reasons: _____

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:

Do you have:

Ability to breathe on your own: YES NO
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
If yes, please explain: _____

High Blood Pressure: YES NO
Low Blood Pressure: YES NO
Difficulty with physical exercise: YES NO
Osteoporosis: YES NO
Osteopenia: YES NO
History of fractures: YES NO
If yes, when and what bones: _____

Advice from your doctor not to exercise: YES NO
Recent surgery (Other than SCI in the last 12 months): YES NO
Pregnancy (now or within the last 6 months): YES NO
Breathing/Lung Problems: YES NO
Asthma: YES NO
Any other disease of the lungs: YES NO
If yes, what and onset date: _____

Muscle, joint or back disorder: YES NO
Any previous injuries: YES NO
If yes, what and when: _____
Were you ever treated by a Dr for this? When: _____

Diabetes: YES NO
Thyroid condition: YES NO
Cigarette smoking: YES NO
If yes, how many packs per day? _____
High Cholesterol: YES NO
Obesity: YES NO
History of heart problems in the immediate family: YES NO
Hernia, or any condition that may be aggravated by intense exercise: YES NO
Muscle Tone: YES NO
If yes, explain intensity and frequency _____

Spasticity YES NO
If yes, explain intensity and frequency: _____

Hardware (Rods, cages, etc): YES NO
If yes, please explain what, when and any issues: _____

Hypersensitivity: YES NO
If yes, please explain: _____

Orthostatic hypotension (Low blood pressure): YES NO
If yes, please explain when you experience it and what your symptoms are: _____

Heterotopic Ossification: YES NO
If yes, please explain: _____

Contracture: YES NO
If yes, please explain: _____

Cognitive impairments YES NO
If yes, please explain: _____

Thermoregulation Issues: YES NO
If yes, please explain your symptoms and preventative measures: _____

Pressure sore(s): YES NO
If yes, please explain location, stage and status: _____

Are you aware of any disease or disorder that would complicate your participation in an exercise program, other than the medical conditions you have checked above? YES NO
If yes, please explain: _____

Has your physician approved your participation in an exercise program? YES NO
Are you accustomed to vigorous exercise? YES NO
Is there any reason not mentioned here why you should not follow a regular exercise program? YES NO
If yes, please explain: _____

Please answer the following questions completely and thoroughly:

List ALL assistive devices you use in everyday life, even if only for short periods (ie:, walker, type of wheelchair, AFO, Abdominal Binder, etc.):

Describe your physical abilities including controlled/uncontrolled movements, tone and/or spasms or joint issues. Be as specific as possible:

Upper Extremity (Arms, Hands, and Fingers): _____

Trunk (Back and Abdominals): _____

Lower Extremity (Hips, Legs, Feet, and Toes): _____

Please list ALL other physical challenges or special considerations (ie: limits in ROM, knee instability, joint/muscle disorder, other health issues):

Are you able to sit independently? YES NO

If no, describe the type and level of support you need: _____

Are you able to stand independently? YES NO

Are you able to perform a sit-up independently? YES NO

Are you able to perform a seated trunk extension independently? YES NO

Are you able to take steps with assistance? YES NO

If yes, please describe the type of assistance needed: _____

Are you able to take steps independently? YES NO

Have you had a recent bone density assessment? YES NO

If yes, please attach a copy of the report with the doctor's interpretation.

NOTE: For safety reasons, clients with no bone density assessment or medical report of bone density assessment will be assumed to have osteoporosis. This may place limitations on the exercises used for your exercise program and prescription.

