

**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](mailto: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: \_\_\_\_\_ *How did you come to learn about NextStep?*

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: \_\_\_\_\_

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**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.):

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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): \_\_\_\_\_

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Trunk (Back and Abdominals): \_\_\_\_\_

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Lower Extremity (Hips, Legs, Feet, and Toes): \_\_\_\_\_

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

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Are you able to sit independently?  YES  NO

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

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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: \_\_\_\_\_

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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.***

Please list all medications you are currently taking including the type, dosage and its function:

<u>Medication</u>	<u>Dosage mg/day</u>	<u>Type (Function)</u>

Please list your previous rehabilitation (physical therapy, occupational therapy, etc.)

<u>Where</u>	<u>Duration (Months)</u>	<u>Results</u>

List your current fitness/wellness regimen. Include any physical activity you do that would be considered exercise or rehab. (ie. FES bike, Standing Frame):

<u>Type</u>	<u>Duration (Minutes/Hours)</u>	<u>Frequency (How often)</u>