

Client Application Form

In an effort to provide the most safe and effective programs, we require all clients to complete this application. Information contained on this application will remain confidential.

Please complete the application and send it via:

Email: walkon@scia.org.au

OR by MAIL to PO Box 6440, Alexandria, NSW 2015

Or by fax to (02) 9669 1761

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

Surname: _____ First Name: _____ Date of Birth: ____/____/____

Address: _____ Suburb: _____ Postcode: _____

Phone/Home: _____ Business: _____ Mobile: _____

Email Address: _____ Do you wish to receive invoicing via email? _____

Occupation: _____ Sports/Hobbies: _____

Age: _____ Sex: _____ Height: _____ Weight: _____ Blood Pressure: _____

In case of emergency, please notify:

Name: _____ Relationship: _____

Phone/Home: _____ Business: _____ Mobile: _____

Level of SCI: _____ Complete or Incomplete Diagnosis: _____

If Incomplete, to what level: _____

Date of injury: ____/____/____ Asia Level/Score: _____

How were you injured?: _____

At what hospital were you treated?: _____ City/State: _____

Treating physician: _____ Date of last medical examination: ____/____/____

Describe your physical abilities (Be as specific as possible, particularly with respect to your arms, trunk and legs):

Upper Extremity: _____

Trunk (ie. Can you sit up): _____

Lower Extremity: _____

Please list any physical problems or special considerations (ie. Osteoporosis/osteopenia, knee instability, joint/muscle disorder, obesity, hypersensitivity, rods in back, other health issues):

Previous rehabilitation (if any): _____ Date last attended: ____/____/____

Results: _____

Have you had a recent bone density assessment? YES NO

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

Results: Normal _____ Other: _____

NOTE: All clients 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 Walk On. We do not interpret bone density reports.

Please list the type, dosage, frequency and function of all medications you are currently taking:

Medication Type	Dosage mg/day	Type(function)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please indicate and specify any of the following conditions that relate to you now OR in the past

- | | | | | | |
|-----------------------------------|--------------------------|--------------------------|--------------------------|-----------------------------|--------------------------|
| High / Low Blood Pressure | <input type="checkbox"/> | Back pain / Sciatica | <input type="checkbox"/> | Migraine / Headaches | <input type="checkbox"/> |
| Stroke / Heart disease | <input type="checkbox"/> | Whiplash / Neck pain | <input type="checkbox"/> | Surgery (other than SCI) | <input type="checkbox"/> |
| Dizzy / Faint spells | <input type="checkbox"/> | Spinal / Disc problems | <input type="checkbox"/> | Varicose veins / Thrombosis | <input type="checkbox"/> |
| IBS / Chrones / Ulcers | <input type="checkbox"/> | Arthritis / Joint injury | <input type="checkbox"/> | RSI / Tendonitis | <input type="checkbox"/> |
| Lethargic / Insomnia | <input type="checkbox"/> | Previous major injuries | <input type="checkbox"/> | History of Chest Pain | <input type="checkbox"/> |
| High cholesterol | <input type="checkbox"/> | Heart/valve disorder | <input type="checkbox"/> | Chronic illness | <input type="checkbox"/> |
| Difficulty with physical exercise | <input type="checkbox"/> | Osteoporosis | <input type="checkbox"/> | Osteopenia | <input type="checkbox"/> |
| History of pathological fracture | <input type="checkbox"/> | Major skin conditions | <input type="checkbox"/> | Asthma / Lung problems | <input type="checkbox"/> |
| Thyroid condition | <input type="checkbox"/> | Diabetes | <input type="checkbox"/> | Obesity | <input type="checkbox"/> |

Do you have a family history of any of the above conditions (Please specify): _____

Other conditions (Please give details): _____

Do you have a hernia or any condition that may be aggravated by intense exercise? _____

Do you have advice from your Doctor not to exercise? _____

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? _____

Are you presently under the care of other professional therapies (ie. Physio)? _____

Do you have any allergies? _____ How much water do you drink per day? _____

Do you smoke or have you smoked in the last 6 months? _____ How many per day? _____

Are you pregnant or have been pregnant in the last 3 months? _____

Are you accustomed to vigorous exercise? _____

Has your physician approved your participation in an intense exercise program? YES NO

Note: This is required prior to your first session at Walk On.

Is there any reason not mentioned here why you should not follow a regular exercise program? If yes, please explain:

Please make any other comments you feel are pertinent to your exercise program: _____

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 Walk On to determine if medical clearance is needed before beginning an exercise program. I understand that if necessary, Walk On 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.

I also understand that participating in the program at Walk On while under the influence of any uncontrolled substance (e.g. marijuana) is strictly prohibited and will result in immediate termination of my participation in the program if detected.

Please print your name clearly: _____

Signature: _____ **Date:** _____

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

Parent or guardian's signature: _____ **Date:** _____

Desired Program Type: Trial Visit Long Term Program Train your Trainer / Home Program

Possible Start Date: _____

How did you hear about Walk On?

- Referred by Doctor, Who? _____ Referred by Client, Who? _____
- Online Search _____ Chat Room (IE: CureCare) _____
- Referred by Walk On Staff, Who? _____ Other _____

The information in this application is confidential and protected under the Privacy Act. The information is to be used solely by the staff of Walk On in determining program eligibility. If you have received this information in error, please destroy the documents.