Date:
Initials:
Please print legibly.
New Member
Updated Profile
(office use only)

Adaptive Sports Medicine Intake Form

<table>
<tr><th colspan="3">CONTACT INFORMATION
Please print legibly
Please use other side or additional paper as needed.</th></tr>
<tr><td>First Name:
____
__</td><td>Last Name:
____________________</td><td>Date:
_________________</td></tr>
<tr><td>Address:
____
__________________</td><td>City:
____
________________</td><td>State: _________ Zip Code: ___________________</td></tr>
<tr><td>Phones:
Mobile:
____
Home:
____
Work:
____________________</td><td>Email Address (PLEASE PRINT):
________@_____</td><td>Employer:
____
__________________________________</td></tr>
<tr><td>Emergency Contact:
____
Relationship:
____
Phone:
__________________</td><td>Primary Physician:
____
____
Phone:
____
__</td><td>Date of Birth: __/ __ /_____ Age: ______
Male / Female Height: ___'___" Weight: _____
Shirt Size: ___</td></tr>
<tr><td colspan="3">Are you your own legal guardian?
If the answer is NO, your legal guardian or legal representative must sign the waiver & release of liability agreement on your behalf. Please provide the following information about your guardian.
First Name: _____________________ Last Name:___________________ Relationship:_________________
Name of person completing this form: _____________________________ Relationship:_________________</td></tr>
</table>

BACKGROUND INFORMATION & INTERESTS
How did you hear about the Program?
What are your adaptive exercise goals?
Have you been a patient of Gaylord? If yes, please specify out-patient or in-patient?

Have you participated in Gaylord's Sports Association?	
Have you been exercising? If so, where?	
Do you have a service dog? Will you be bringing the dog to the program?	
I am Interested in the Following Exercise:	

❑ **Flexibility**
❑ **Endurance**
❑ **Strength**
❑ **Power**
	❑ **Group Strengthening Classes**
	❑ **Individualized Training**
	❑ **Specialty Classes**
	    ❑ **Yoga**
	    ❑ **Boxing**
	    ❑ **Zumba**
	❑ **Adaptive Sports with Gaylord's Sports Association**

If you are interested in adaptive sports offered by Gaylord's Sports Association, please check all that apply:	
❑ Archery ❑ Boccia ❑ Wheelchair Curling ❑ Cycling ❑ Fishing ❑ Golf ❑ Kayaking	❑ Wheelchair Rugby ❑ Rock Climbing ❑ Skiing, Downhill ❑ Sled Hockey ❑ Wheelchair Tennis ❑ Triathlon ❑ Water Skiing ❑ Yoga
Other Sports of Interest:	
❑ Indoor Cycle Training ❑ Sailing ❑ Seated Fencing ❑ Fitness/Strength Classes ❑ SCUBA Diving ❑ Horseback Riding	❑ Road Racing/Running ❑ Target Shooting ❑ Cross Country Skiing ❑ Wheelchair Basketball ❑ Rowing ❑ Swimming
Do you have intermediate or advanced level skills in any of the above activities? (pre-injury or post-injury)? If so, please describe: ____	
Would you like to learn more about the Gaylord Sports Association, adaptive sports program?________ If yes, we will share your contact information and a member of the Gaylord Sports Association staff will be in contact with you.	

PRIMARY DIAGNOSIS Date of Injury or Onset: ____________________	

o **Spinal Cord Injury**
    o **Level** _______
    o **Complete**
    o **Incomplete**
	o **Amputee**
	    o **Leg: Right or Left**
	    o **Arm: Right or Left**
	        ▪ **Above Elbow**
	        ▪ **Below Elbow**

o **Traumatic Brain Injury**	o **Multiple Sclerosis**
o **CVA/Stroke** o **Location**	o **PTSD**

o **Acquired Brain Injury**
    o **Please Specify:**
	o **Other Diagnosis (orthopedic, neurologic, spina bifida, cerebral palsy):**
	    o **Please provide details**

MEDICAL HISTORY

Please check if you have a history of any of the below items:

Anxiety/Panic Disorders	Asthma	Cancer
Readjustment issues since injury	Prescribed blood thinners such as Coumadin	Pressure Ulcers
Chronic pain requiring narcotics	Cardiac Condition(Coronary Heart Disease, Myocardial infarction)	Acute Tuberculosis
Drug/Alcohol Use	Heat Stroke	COPD/Pulmonary Disease
		Hepatitis
		Skin Infections

Surgical Procedures: Date(s) _________________ Type: __________________________

Autonomic Dysreflexia If yes, How frequently?/Last occurrence:______________________

Diabetes Type:__________

Spinal Surgery Date:___________

Hospitalization within past year. If yes, Date and Reason: ______________________________

Have you ever had seizures? Date of last seizure: ____________
Type of seizure (Focal, Grand Mal, Petite Mal): ___________ How frequently?________________

MEDICAL INFORMATION

Do you have ALLERGIES? Please List:
Do you have Dietary Requirements? Please Describe:
Do you SMOKE? (Please not that this program complies with Gaylord Hospital's No Smoking Policy)
Are you currently taking any MEDICATIONS? If so, please list and indicate any pertinent side effects (please attach a list if you need additional space):
Do you currently have any open wounds? If yes, please list location/stage/condition:
Do you have any Bladder or Bowel Adaptations (such as a catheter or leg bag)? Please list:
Do you require an attendant (to assist you)? If YES, will you bring someone to assist you? (We are not able to provide assistance with personal care needs)
Are you able to obtain a doctor's note for participation in this program? (A doctor's note may be required based on medical history or requirements for participation in specific activities)

PHYSICAL FUNCTIONING

Do you use a wheelchair for mobility? If yes, what type (manual, power)? ________________
Do you require assistance for wheelchair mobility? ____
Do you use an assistive device(s) for mobility? If yes, what type (cane, walker)?___________
Do you use other adaptive equipment for mobility? If yes, please specify:_______________________________
Do you require assistance to transfer yourself from one surface to another, such as into a vehicle or onto the floor? If yes, please describe: ____
Do you have any difficulty breathing?

Do you need to limit your activities for any reason? Please describe: ____________________
Do you participate in any exercise program? Please describe: ________________________
Do you have limited range of motion? Please indicate location and describe:____
How would you describe your endurance: Excellent, Good, Fair, or Limited (please circle one)
Do you have impaired strength, muscle tone, spasticity, or paralysis? If yes, indicate affected area and describe:
Do you have difficulty with balance? Describe:
Do you have any difficulties with feeling hot or cold normally?

VISION & HEARING
Do you wear glasses?
Do you wear contact lenses?
Please mark any of the following that are true about your vision: o Legally blind (best corrected <20/200ou) o Totally blind o Double vision o Visual Field Loss, Please Describe: o Other Visual Problems (Perceptual, Depth, Neglect, etc): Please describe:
Do you have a hearing impairment? Please Explain: **If so, please specify:** o Left Ear Affected o Right Ear Affected o Both Ears Affected o Do you use a hearing aide?

COMMUNICATION
Do you have any difficulty making needs known to instructor?
Do you have difficulty speaking or communicating?
Do others have difficulty understanding you?
Do you have difficulty remembering things?
Do you have difficulty in learning new things?
Do you have difficulty following directions? If yes to any of these questions, PLEASE EXPLAIN: ____
Do you use non-verbal communication? If Yes, which type: _______________________

BEHAVIOR/EMOTIONS
Are you ever impulsive?
Do you become easily frustrated?
Do you become angry easily?
Do you ever physically or verbally lose control? If yes, please describe in detail: ____ What are the best ways to help you gain control? ____

Do you know of any reason you should not participate in any part of this program?
Yes No If yes, please explain here: ____

PLEASE PROVIDE ANY ADDITIONAL INFORMATION THAT MAY HELP US TO PREPARE FOR A SUCCESSFUL EXPERIENCE:
____
____

ACKNOWLEDGEMENT

By signing below, I verify that the above information is current and accurate. I understand that the above information will be kept confidential. In order to provide a safe and fun experience your information may be shared with: (1) Gaylord Adaptive Sports Medicine staff, coaches, or instructors (2) Sports Association staff, coaches or instructors (3) other adaptive sports programs who will be working with you (4) medical professionals in case of emergency (5) as required for Sports Medicine grant reports. I understand that it is my responsibility to inform the Adaptive Sports Medicine Program regarding changes to my: (1) contact information such as address, phone and email; (2) medical status including new diagnosis, surgery or medical changes; (3) any other information that is relevant to the safety of myself or others regarding my participation in Adaptive Sports Medicine or other Gaylord affiliated programs.

Printed Name of Participant or Legal Guardian: ____

Signature of Participant or Legal Guardian: ___________________________ Date: _______________

Please Mail, Fax or Email completed member profile to:
Gaylord Physical Therapy Orthopedics and Sports Medicine, 1154 Highland Avenue, Cheshire CT 06410,
klevesque@gaylord.org or psilverio@gaylord.org
FAX: Fax: (203) 294-8705 Attn: Adaptive Sports Medicine Program, PHONE: 203-670-3533