PUSHING BOUNDARIES

Exercise, health and hope for people with paralysis

Health History Form

Overview

Name:		Today's Date:	
Pronouns:		Date of Birth:	
Email:		Phone:	

Is it okay to email you about treatment details, scheduling, and/or billing topics?	Yes ☐ No ☐	Is it okay to leave you detailed phone messages?	Yes ☐ No ☐

Address:	
City, State, Zip:	
Local Address: *(if different)*	
City, State, Zip:	

Billing Contact *(if Different):*		Phone:	
Email:		Relationship:	
Marital Status:	☐ M ☐ S ☐ W ☐ D	Spouse/Partner Name:	

Emergency Contact:		Phone:	
Email:		Relationship:	
Transportation/Caregiver Contact *(if different):*		Phone:	
Email:		Relationship:	

Bone Density

All clients must submit a bone density assessment performed within the last year (with the doctor's review & interpretation) if walking is not the primary mode of ambulation for the past 12 months. Please enclose a copy of the report for our files. Pushing Boundaries does not evaluate bone density reports.

Have you Had a Bone Density Test? ☐ Yes ☐ No

Date of Test:	Results:
Internal Use Only	
Copy Received:	Date Received:

Demographics

Collecting Demographic data helps Pushing Boundaries apply for funding, grants, and report statistics to our community. Specific clients are never cited in these uses and individual information remains anonymous.

Race/Ethnicity:	
Cultural/Religious Identification:	
Gender Identity:	
Employment Status:	
Veteran Status:	

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Health History

Primary Diagnosis/Primary Injury:		
Date of Diagnosis/Injury:		
(SCI) Level/Classification:	☐ Complete	☐ Incomplete

Treating Hospital:		
Primary Physician:	Phone:	
Date of Last Physical Exam:	Pregnancy Status:	

Other CURRENT Therapy Services (please attach additional sheet if needed)

Provider Name	Type of Therapy (PT, OT, Speech, Massage, Aqua, etc)

Past Fractures (please attach additional sheet if needed)

Details	Date

Past Surgeries (please attach additional sheet if needed)

Details	Date

Allergies (please attach additional sheet if needed)

Do you experience regular breathing problems?	☐ Yes	☐ No
If yes, please explain:		
Have you fallen in the past six months?	☐ Yes	☐ No
If yes, please explain:		

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Health History (continued)

In the past month, have you had pain when you are not doing physical activity?	☐ Yes	☐ No
Do you feel pain in your chest when you are doing physical activity?	☐ Yes	☐ No
Has your physician ever stated that you have a heart condition, and should only do specific physical activity recommended by a physician?	☐ Yes	☐ No
Is your physician currently prescribing or recommending medication in relation to blood pressure or heart health?	☐ Yes	☐ No
If you answered 'Yes' to the above, please list Medications:		

Do you Smoke?	☐ Yes	☐ No	How Much Per Day:
Have you Ever Smoked?	☐ Yes	☐ No	Quit Date:

Please 'X' any that apply (and provide age of onset where appropriate)

Condition	Self	Age of Onset	Father	Mother
High Blood Pressure	☐		☐	☐
High Cholesterol	☐		☐	☐
Diabetes	☐		☐	☐
Heart Disease	☐		☐	☐
Bypass Surgery	☐		☐	☐
Stroke	☐		☐	☐
Thyroid Condition	☐		☐	☐

Any additional notes relevant to your care, history, and safety:	

I have completed this Health History Form accurately and to the best of my knowledge. I understand it is my responsibility to disclose any and all pertinent medical data to Pushing Boundaries and that Pushing Boundaries reserves the right to request medical clearance and/or a bone density scan with physician's evaluation prior to the start of any exercise program, change in health status, or shift in exercise therapy program components.

Pushing Boundaries reserves the right to deny, suspend, or discontinue an exercise therapy session or program based on any health and/or safety concerns witnessed by the exercise therapy team.

_____ _____

Client Signature *Date*

_____ _____

Legal Guardian or Caregiver (Please Print) *Relationship*

_____ _____

Legal Guardian or Caregiver Signature *Date*

Click Below to Save a Copy

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