



The Center For Individuals With Physical Challenges

Member ID No.
Date
Onset Date

APPLICATION FOR MEMBERSHIP

CONFIDENTIAL RECORD: Information contained will not be released except with authorized permission to do so.

Last Name		First		Middle	
Birthdate	Age	Sex	Marital Status	Social Security No.	Phone No.
Address			City	State	Zipcode
Email Address		Occupation			Work Ph.
Person to Notify in Emergency		Relationship			Phone No.
Insurance Provider		Primary Physician			Phone No.

FAMILY HISTORY: Do you or any blood relative currently have any of the following?

HIGH BLOOD PRESSURE	<input type="checkbox"/> Yes <input type="checkbox"/> No	Relationship _____	Onset Age _____
STROKE	<input type="checkbox"/> Yes <input type="checkbox"/> No	Relationship _____	Onset Age _____
DIABETES	<input type="checkbox"/> Yes <input type="checkbox"/> No	Relationship _____	Onset Age _____
CHEMICAL DEPENDENCY — ALCOHOL / DRUGS (INCLUDING PRESCRIPTION DRUGS)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Relationship _____	Onset Age _____
HEART DISEASE (ANGINA, HEART ATTACK, ANGIOPLASTY, HEART SURGERY)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Relationship _____	Onset Age _____

MEDICAL HISTORY

<p>Do you have a physical disability? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, what functional abilities have been affected by your physical disability?</p> <p><input type="checkbox"/> Vision <input type="checkbox"/> Mobility <input type="checkbox"/> Comprehension/ Cognition</p> <p><input type="checkbox"/> Dexterity <input type="checkbox"/> Hearing <input type="checkbox"/> Speech/ Language</p> <p><input type="checkbox"/> Decisionmaking <input type="checkbox"/> Memory <input type="checkbox"/> Other:</p>	<p>Do you require assistance with any of the following?</p> <p><input type="checkbox"/> Restroom <input type="checkbox"/> Mobility <input type="checkbox"/> Transfers</p> <p><input type="checkbox"/> Other:</p> <p>Do you require assistance to participate in programming?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
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PLEASE EXPLAIN THE CAUSE OR REASON FOR YOUR PHYSICAL DISABILITY (i.e. Cerebral Palsy, CVA, Diabetes, Osteoporosis, Spinal Cord Injury, Visual Impairment, etc.): _____

LIST ANY PRESCRIBED MEDICATIONS YOU ARE NOW TAKING AND WHAT THEY ARE FOR: _____

LIST ANY OVERTHECOUNTER MEDICATIONS OR DIETARY SUPPLEMENTS YOU ARE NOW TAKING: _____

ARE YOU ALLERGIC TO ANY MEDICATIONS? Yes No If Yes, please list: _____

MEDICAL HISTORY *continued*

LIST ANY SERIOUS DISEASE OR INJURY YOU HAVE HAD WHICH REQUIRED HOSPITALIZATION: _____

DO YOU HAVE ANY INFECTIOUS DISEASES? Yes No If Yes, please list: _____

EXPLAIN ANY OTHER SIGNIFICANT MEDICAL PROBLEMS THAT YOU CONSIDER IMPORTANT FOR US TO KNOW: _____

HAVE YOU EVER HAD:

- Headaches Dizzy Spells Convulsions or Seizures
 Weakness of an Arm or Leg Double Vision

HAVE YOU EVER HAD SHORTNESS OF BREATH:

- Doing your usual work Accompanied by wheezing
 Climbing a flight of stairs Which awakens you at night

DOES THIS SENSATION OCCUR:

- At rest When walking up a hill or against the wind When walking rapidly or in cold weather
 With exertion During sleep which awakens you When carrying an object
 When upset or excited During or after meals

HAS YOUR DOCTOR EVER SAID YOU HAD OR HAVE:

- Heart Trouble Do you have extra, skipped or rapid heart beats/ Palpitations? Yes No
 An Abnormal Electrocardiogram (ECG / EKG) Do you experience pain in either leg while walking? Yes No
 Heart Murmur Past Present Have you had a stress test in the last year? Yes No

PAST OR CURRENT ORTHOPEDIC OR NEUROLOGICAL LIMITATIONS:

- Have you ever had surgery or injury to your neck, back, arms or legs? If so, please explain: _____

- Do you have any restrictions or limitations regarding arm or leg movement or your ability to lift? If so, please explain: _____

- Do you have frequent or occasional joint pain? If so, please explain: _____

- Have you ever sustained a neurological injury or illness that has resulted in any physical limitations (stroke, spinal cord injury, head trauma, multiple sclerosis, Parkinson's, etc.) If so, please explain: _____

- Do you have any difficulties with communication? Speaking Understanding If so, please explain: _____

MEDICAL HISTORY *continued*

Please list your present height: _____ ft. _____ in. and your current weight: _____ lbs.

LIFESTYLE HISTORY

How do you describe the stress in your everyday life? Slight Moderate High
How do you describe your lifestyle? Sedentary Active Heavy Labor
Average hours of sleep per night? _____ Average hours of work per week? _____

PERSONAL HABITS

Do you regularly use tobacco products? Yes No Approximate intake per day? _____
Do you regularly drink beer and/or alcohol? Yes No Approximate intake per day? _____
At any time in the past were you a heavy drinker? Yes No (6 oz. / 4 bottles or more of alcohol/ beer per day)
Do you usually drink more than 6 cups of coffee per day? Yes No
Do you drink other caffeinated beverages? Yes No Approximate intake per day? _____

EXERCISE HISTORY

In what sports or recreational activities are you active? _____
Check your exercise preferences: Walk Jog Bike Swim Tennis Weight Training Organized Classes
 Other: _____ How often? _____
Do you have discomfort, shortness of breath or pain with moderate exercises? Yes No If Yes, please explain: _____

What problems, if any, have you had *previously* while exercising? _____

MEMBERSHIP AGREEMENT

All exercise and participation is done at the risk of each Member or his/ her guest. By applying for membership with The Center for Individuals with Physical Challenges, applicant understands and agrees that he/ she waives his/ her rights and the rights of his/ her heirs, administrators, executors, successors and assigns to all claims arising out of the use of The Center premises, Center vehicles, Center sponsored off-site activities, including but not limited to personal injury, including bodily injury and death, and all property damage. The Center its staff, volunteers and its officers assume no liability for any accident or injury, personal or otherwise.

I grant The Center permission to contact my physician and/ or other healthcare professionals regarding my disability. Furthermore, to insure the continued accuracy of my medical information, I agree to notify the Director of Member Services of any and all changes in my medical status, with the understanding a *new medical release* may be required.

I grant The Center permission to use my name, photo and/or likeness in any public relations, marketing or fundraising materials. Yes No

BY SIGNING THIS APPLICATION, I INDICATE THAT I HAVE READ THE ABOVE AND UNDERSTAND AND AGREE TO ITS TERMS.

Applicant Signature

Date

If the application was completed by another individual on the applicant's behalf, please provide the following contact information:

Name

Relationship to applicant
(spouse, dependent, caregiver, medical staff, etc.)

Contact Phone No.

Medical Release

To be completed by Applicant's Physician

Your patient has applied for membership with The Center for Individuals with Physical Challenges. The Center provides rehabilitative services, therapeutic recreation, and leisure activities for persons with physical disabilities. The information you provide below will assist us in evaluating the applicant's specific needs.

_____ has a physical limitation that is his/ her **primary disability**? Yes No
(NAME)

A. Please explain the cause or reason for disability: _____

B. Please list any other disabilities: _____

C. Please list any other current health problems: _____

Please assess the functional level of the patient in the following areas, 1 being the **LOWEST** level of functioning and 5 being the **HIGHEST**:

___ Vision ___ Speech ___ Hearing ___ Social Skills ___ Toileting/ Elimination ___ Independent Decision-Making
___ Gross Motor ___ Fine Motor ___ Ambulation ___ Feeding ___ Comprehension/ Cognition

Please specify if patient uses any of the following: Wheelchair Walker Other device, specify: _____

Comments: _____

To the best of your knowledge, does the patient have a history of problems with any of the following:

Impulse control/ inability or refusal to follow instructions Yes No

Wandering off when in open environments Yes No

Inappropriate social interaction Yes No

Aggressive behaviors Yes No

Inappropriate sexual behavior Yes No

Patient is referred by me for health reasons to participate in this programming without restrictions with the following restrictions:

Please list recommended activities for patient: _____

Any additional comments? _____

Name of the person in your office we may contact regarding the appropriateness of specific activities:

Name: _____ Phone No. _____ Ext. _____

Physician's Signature

Date

PLEASE RETURN COMPLETED DOCUMENT TO:

The Center for Individuals with Physical Challenges

Attn: Director of Member Services

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www.tulsacenter.org