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	☐ Yes	☐ No	Relationship _____	Onset Age _____
STROKE	☐ Yes	☐ No	Relationship _____	Onset Age _____
DIABETES	☐ Yes	☐ No	Relationship _____	Onset Age _____
CHEMICAL DEPENDENCY — ALCOHOL / DRUGS (INCLUDING PRESCRIPTION DRUGS)	☐ Yes	☐ No	Relationship _____	Onset Age _____
HEART DISEASE (ANGINA, HEART ATTACK, ANGIOPLASTY, HEART SURGERY)	☐ Yes	☐ No	Relationship _____	Onset Age _____

MEDICAL HISTORY

Do you have a physical disability? ☐ Yes ☐ No

If yes, what functional abilities have been affected by your physical disability?

☐ Vision ☐ Mobility ☐ Comprehension/ Cognition
☐ Dexterity ☐ Hearing ☐ Speech/ Language
☐ Decisionmaking ☐ Memory ☐ Other:

Do you require assistance with any of the following?

☐ Restroom ☐ Mobility ☐ Transfers
☐ Other:

Do you require assistance to participate in programming?

☐ Yes ☐ No

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.

PLEASE NOTE: PHYSICIAN MUST COMPLETE MEDICAL RELEASE INFORMATION ON REVERSE SIDE OF APPLICATION

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
815 South Utica Avenue Tulsa, OK 74104
Ph: 918-584-8607 Fax: 918-584-8646
www.tulsacenter.org