Strive SCI
Client Application Form

In an effort to provide the most safe and effective programs, Strive SCI (operated by Spinal Fit Society) requires all Clients to complete this application. Information contained on this application will remain confidential.

Please complete the application and send it to:

info@strivesci.ca

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.

Client Information

Client Name: ____ Date: ____________________________

Address: ____

City: ______________________________Province: __________ Postal Code: _______________

Home Phone: _________________________________Cell Phone: _____________________________________

Email (Required): ____

Contact Information (if different than above)

Client Name: ____ Date: ____________________________

Address: ____

City: ______________________________Province: __________ Postal Code: _______________

Home Phone: _________________________________Cell Phone: _____________________________________

Email (Required): ____

Strive SCI sends our Clients billing invoices via email, please provide your billing email address above.

Date of Birth: ____________ Age: ___________ Height: ___________ Weight: _________ Sex: __________

Please note Strive SCI requires all Clients to maintain a healthy weight. For the safety of our staff, all Clients must meet average height to weight parameters.

Level of Spinal Cord Injury: ________________ Complete or Incomplete Diagnosis: _________________________

Date of injury: ______________________________ Asia Level/Score: ___________________________________

How were you injured? ____

At what hospital were you treated? __________________________ City/Province: _________________________

Treating physician: _________________________ Date of Last Medical Examination: _____________________

In case of emergency, please notify:

Name: ______________________________________Relationship: ____________________________________

Phone (home): _______________________________ Phone (work): ___________________________________

List any assistive devices you use in your everyday life, even if only at home (ie: crutches, walker, wheelchair (manual or motorized), KFO, AFO, Abdominal Binder: ____

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Describe your physical abilities include controlled movements, tone or spasms. Be as specific as possible:

Upper Extremity (Example of tone and spasm: fists clench, biceps spasm causing the elbow to bend or triceps spasm causing the elbow to lock):

Trunk: Can you maintain balance with sitting with no support? When you lie flat on your back do you get a strong contraction through your stomach that knocks the wind out of you? Does your lower back spasms and pulls you down into a supine position from a sitting position?

Lower Extremity (Example: Your toes point or heels tap while seated in your chair (calf spasm), when you lie down flat on your back, your legs kick up (quadriceps spasm) or knees pull to your chest (hamstrings/hip flexors spasm)):

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: Clients must obtain a bone density assessment if required by their doctor and are required to submit a copy of the bone density report with the doctor's interpretation before their first session at Strive SCI. We do not interpret bone density reports.

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

Medication Type	Dosage mg/day	Type (Function)

Please answer Yes or No to the following. Indicate "Yes" for those that apply to you at present or have applied to you in the past:

History of chest pain: ____

History of heart disease or any other heart/valve disorder: ___________________________________

Any chronic illness or condition: ____

High Blood Pressure: ________ Low Blood Pressure: ________ Difficulty with physical exercise: _______________

Osteoporosis: ______________ Osteopenia: _______________History of Pathological fracture: _______________

Advice from your doctor not to exercise: ____

Recent surgery (Other than SCI in the last 12 months): ____

Pregnancy (now or within the last 3 months): ____

Breathing/Lung Problems: __________ Asthma: __________ Any other disease of the lungs: _____________

Muscle, joint or back disorder, or any previous injury still affecting you: ____________________________________

Diabetes: ____________ Thyroid condition: _____________ Cigarette smoking: ________________________

If yes, how many packs per day? ___________ High Cholesterol: ____________ Obesity: _____________________

History of heart problems in the immediate family: ____

Hernia, or any condition that may be aggravated by intense 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? ____

If yes, please explain: ____

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

NOTE: This is required prior to your first session at Strive SCI.

Are you accustomed to vigorous exercise? ______________

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

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

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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 Strive SCI, to determine if medical clearance is needed before beginning an exercise program. I understand that if necessary, Strive SCI 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 Strive SCI, while under the influence of any controlled or uncontrolled substance is strictly prohibited.

Please print your name clearly: ____

Signature: ____ Date: ________________________

If under 18, name of parent or guardian: ____________________________ Relationship: ________________

Parent or guardian's signature: ____________________________________ Date: _______________________