Client Questionnaire:

Welcome to Movement Revolution! We are excited to welcome you into our program.
To begin, please complete the following documents:

1. Member Waiver & Policies
2. Physician's Medical Release
3. List of Medications

Date ____/____/____ Age__________ Gender(circle) Male or Female

Name/# ____ DOB _____/______/______

Address ____

City ____________________________ Zip Code ____________________

Home phone ___________________________Cell phone ____________________________

Business Phone _________________________Email _________________________________

How did you hear about Movement Revolution (circle)?

Referral / Media /Website / Other__________

Emergency contact Information

Name ____

Relationship to applicant____

Address ____

City ____________________________ Zip Code ____________________

Home phone __________________________Cell phone _____________________________

Email ____________________________________

Media Release- This media release allows Movement Revolution to share and utilize any pictures and videos that may include you from our classes, programs, and educational seminars on Facebook, other social media platforms, and any other promotional purpose.

I ______________________ (member name) allow MVMT Revolution LLC (Movement Revolution) to publish or broadcast my image/likeness and/or name for promotional purposes associated with MVMT Revolution LLC (Movement Revolution).

Signature ________________________

Health Information

Primary diagnosis: ___________________________________

Date of diagnosis ____/____/____

Primary Doctor ___________________ Hospital___________________

Neurologist ___________________ Hospital___________________

Cardiologist ___________________ Hospital___________________

May we contact your doctor(s) and share any relevant health information with them?

Yes or No

Primary Symptoms (brief description)

Balance____

Weakness/Difficulty Moving Limbs ____

Vision Impairment ____

Speech/Swallowing ____

Fatigue ____

Rigid Muscles____

Pain____

Numbness or Loss of Sensation____

Bowel/Bladder____

Memory____

Other____

Have you lost your balance or fallen in the past year (circle one)? Yes No

If yes, how many have you had in the past 3 months and explain when and where they happened:____

____

Health Information

Physical Activity Questionnaire (PAR-Q)

	Questions	Yes	No
1	Has your doctor ever said that you have a heart condition and that you should only perform physical activity recommended by a doctor?		
2	Do you feel pain in your chest when you perform physical activity?		
3	In the past month, have you had chest pain when you were not performing any physical activity?		
4	Do you lose your balance because of dizziness or do you ever lose consciousness?		
5	Do you have a bone or joint problem that could be made worse by a change in your physical activity?		
6	Is your doctor currently prescribing any medication for your blood pressure or for a heart condition?		
7	Do you know of any other reason why you should not engage in physical activity?		

If you have answered "Yes" to one or more of the above questions, consult your physician before engaging in physical activity. Tell your physician which questions you answered "Yes" to. After a medical evaluation, seek advice from your physician on what type of activity is suitable for your current condition.

Do you take medicine for depression? Yes No

Have you been diagnosed with diabetes? Yes No

If yes, what type? ___________________________________

Have you had deep brain stimulation? Yes No

Do you feel dizzy or unsteady when making sudden changes in movement, such as bending down or turning quickly? Yes No

Do you feel unsteady when you are walking or climbing stairs? Yes No

Do you have difficulty sitting down or rising from a seated or lying position? Yes No

Do you have a history of HIGH or LOW blood pressure? (please circle)

Do you have arthritis or problems with your bones and/or joints? Yes No

If yes, please explain ____

Have you been hospitalized in the past 3 months? Yes No

If yes, please explain: ____

Exercise History

Have you participated in Physical Therapy, Occupational Therapy, or Speech Therapy? **circle all that apply**

If yes, when was the last time you completed each of the circled above responses?

____

If yes, what was your therapist's name(s)? ____________________________________
Clinic(s) ____

What was your primary focus while in therapy?

____

What exercise activities to do regularly participate in? (circle all that apply)

Walking Biking Jogging Yoga Pilates Zumba None Other:

Please describe your current exercise routine:

____
____

Have you been diagnosed with any other medical problems we should be aware of?
____
____

Are there any activities you enjoy that you've stopped since being diagnosed?
____

What are your primary goals for working with us at Movement Revolution?

1. ____
2. ____
3. ____

These are all the aspects of wellness that we can assist you with. Please circle the ones of most interest to you.

Strength	Balance	Endurance
Young Onset Services	Home Exercise	Falling
Diet/Nutrition	Sleep	Social Wellbeing
Caregiving/Homecare	Support/Mentorship	Cognition