MOVEMENT REVOLUTION

Client Information

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

1. Member Information Form & Media Release
2. Physician's Medical Release
3. Stroke Impact Scale
4. Personal Waiver and Release of Liability

Date ____/____/____

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 ___________________________________

Diagnosis Information

Date of diagnosis ____/____/____

Primary Doctor seen since your Stroke ____________________

Hospital____________________

Symptoms (brief description)

Hemiparisis____

Weakness ____

Vision Impairment ____

Shortness of breath ____

Fatigue ____

Speech Impairment ____

Other ____

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

Do you use an assisted device (circle one)? Yes No

If yes, device(s) used: ____

List of Medications:

___________________ ___________________ ___________________

___________________ ___________________ ___________________

___________________ ___________________ ___________________

Timing of Medications: __________________________

Health Information

Do you have a heart condition or have you experienced any chest pain in the last

6 months? Yes No If yes, please explain ____________________________________

____

Do you take medicine for depression? Yes No

Have you been diagnosed with diabetes? Yes No

If yes, what type? ___________________________________

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

Are you currently active with any physical activities? Yes No

If yes, what type?

____

____

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

If yes, please explain ____

____

Have you recently participated in Physical Therapy? Yes No

If yes, what was your therapist's name? _________________ Clinic ___________________

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

____

____

What do you wish to gain from joining the Movement Revolution?

____

____

Media Release

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 __________________________