Client Application

Send the following completed application to:

Email: chriscorpuz@reneu-health.com
Fax: (619) 858-2210

This application *must be filled out completely*. Information contained on this application will remain confidential. Once your application is reviewed, we will contact you. If applicant is under the age of 18, a parent or legal guardian must sign this application.

NOTE: Completion of this application does not guarantee your participation in our program.

Personal and Contact Information (All information is required)

Date: _____

Full Name: _____

Date of Birth: _____ Age: _____

Address: _____

City: _____

State: _____ Zip Code: _____

Home Phone: _____

Cell Phone: _____

Email (Required): _____

In case of emergency, please notify:

Name: _____ Relationship: _____

Phone (home): _____ Phone (work): _____

Medical Information

Height: _____ Weight: _____ Sex: _____

Neurological Disorder (Check all that apply)

_____ SCI _____ TBI _____ MS

_____ Stroke _____ CP _____ Other: _____

If other, please describe: _____

If SCI, cause of injury: _____

Level of injury: _____ ASIA score: _____

If MS, what type? _____

Date of Injury/Diagnosis: _____

Hospital where initially treated: _____

Treating physician: _____ City& State _____

Have you had any recent hospitalizations (within the last 12 months) _____

If "yes", then list dates and reasons: _____

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:

Do you have:

Ability to breathe on your own: ☐ YES ☐ NO

History of chest pain: ☐ YES ☐ NO

History of heart disease or any other heart/valve disorder: ☐ YES ☐ NO

Any chronic illness or condition: ☐ YES ☐ NO
If yes, please explain: _____
_____

High Blood Pressure: ☐ YES ☐ NO

Low Blood Pressure: ☐ YES ☐ NO

Difficulty with physical exercise: ☐ YES ☐ NO

Osteoporosis: ☐ YES ☐ NO

Osteopenia: ☐ YES ☐ NO

History of Pathological fracture: ☐ YES ☐ NO

Advice from your doctor not to exercise: ☐ YES ☐ NO

Recent surgery (Other than SCI in the last 12 months): ☐ YES ☐ NO

Pregnancy (now or within the last 3 months): ☐ YES ☐ NO

Breathing/Lung Problems: ☐ YES ☐ NO

Asthma: ☐ YES ☐ NO

Any other disease of the lungs: ☐ YES ☐ NO

Muscle, joint or back disorder, or any previous injury still affecting you: ☐ YES ☐ NO

Diabetes: ☐ YES ☐ NO

Thyroid condition: ☐ YES ☐ NO

Cigarette smoking: ☐ YES ☐ NO
If yes, how many packs per day? _____

High Cholesterol: ☐ YES ☐ NO

Obesity: ☐ YES ☐ NO

History of heart problems in the immediate family: ☐ YES ☐ NO

Hernia, or any condition that may be aggravated by intense exercise: ☐ YES ☐ NO

Tone ☐ YES ☐ NO
If yes, explain intensity and frequency _____

Spasticity ☐ YES ☐ NO
If yes, explain intensity and frequency: _____

Hardware (Rods, cages, etc): ☐ YES ☐ NO
If yes, please explain: _____
_____

Hypersensitivity: ☐ YES ☐ NO
If yes, please explain: _____
_____

Orthostatic hypotension (Low blood pressure?): ☐ YES ☐ NO

If yes, please explain when you experience it and what your symptoms are: _____

Heterotopic Ossification: ☐ YES ☐ NO
If yes, please explain: _____

Contracture: ☐ YES ☐ NO
If yes, please explain: _____

Cognitive impairments ☐ YES ☐ NO
If yes, please explain: _____

Thermoregulation Issues: ☐ YES ☐ NO
If yes, please explain your symptoms and preventative measures: _____

Pressure sore(s): ☐ YES ☐ NO
If yes, please explain location and stage: _____

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? ☐ YES ☐ NO
If yes, please explain: _____

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

Are you accustomed to vigorous exercise? ☐ YES ☐ NO

Is there any reason not mentioned here why you should not follow a regular exercise program? ☐ YES ☐ NO
If yes, please explain: _____

Please answer the following questions completely and thoroughly:

List *ALL* assistive devices you use in everyday life, even if only for short periods (ie:, walker, type of wheelchair, AFO, Abdominal Binder, etc.):

Describe your physical abilities including controlled/uncontrolled movements, tone and/or spasms or joint issues. Be as specific as possible:

Upper Extremity (Arms, Hands, and Fingers): _____

Trunk (Back and Abdominals): _____

Lower Extremity (Hips, Legs, Feet, and Toes): _____

Please list *ALL* other physical challenges or special considerations (ie: limits in ROM, knee instability, joint/muscle disorder, other health issues):

Are you able to sit independently? ☐ YES ☐ NO
If no, describe the type and level of support you need. _____

Are you able to stand independently? ☐ YES ☐ NO

Are you able to perform a sit-up independently? ☐ YES ☐ NO

Are you able to perform a seated trunk extension independently? ☐ YES ☐ NO

Are you able to take steps with assistance? ☐ YES ☐ NO

If yes, please describe the type of assistance needed: _____

_____

Are you able to take step independently? ☐ YES ☐ NO

Have you had a recent bone density assessment? ☐ YES ☐ NO

If yes, please attach a copy of the report with the doctor's interpretation.

NOTE: For safety reasons, clients with no bone density assessment or medical report of bone density assessment will be assumed to have osteoporosis. This may place limitations on the exercises used for your exercise program and prescription.

Please list all medications you are currently taking including the type, dosage and its function:

Medication	Dosage mg/day	Type (Function)

Please list your previous rehabilitation (physical therapy, occupational therapy, etc.)

Where	Duration (Months)	Results

List your current fitness/wellness regimen. Include any physical activity you do that would be considered exercise or rehab. (ie. FES bike, Standing Frame):

Type	Duration (Minutes/Hours)	Frequency (How often)

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Program Terms

THIRD PARTY BILLING.
Clients are responsible for payment until third party coverage begins. Reneu Health will not follow up with these organizations on your behalf.

_____ Initial

INSURANCE COVERAGE
Reneu Health is not a medical facility and does not direct bill insurance companies. Clients will need to submit invoices directly to any third party either for reimbursement or to request payment to Reneu Health.

_____ Initial

NATIONAL TRANSPLANT ASSISTANCE FUND (NTAF)
Clients who have an account with NTAF are responsible for mailing check requests accompanied by the monthly invoice. Please contact NTAF for their policies and procedures: (800) 642-8399.

_____ Initial

AUTHORIZATION FOR AUDIO / VISUAL CONSENT
I hereby consent and authorize the taking of photographs, movies, films, videotapes, tape recordings, or reproductions of the persons who are hereby applying for program participation and consent to use, copyright, license, publication or broadcast of the same for advertising, educational, promotional, or publicity purposes on the part of the Reneu Health and by its affiliated and associated organizations, including its directors, officers, agents, and employees. I hereby grant and assign to Reneu Health the right, title, and irrevocable authority and interest to such Reproductions. I waive any and all claims for compensation and waive any and all claims related to or arising out of the publication and dissemination of the same of any lawful purposes. I further authorize the communication of information concerning the undersigned in connection with the utilization of such Reproductions by Reneu Health and its affiliated or associated organizations, and their respective directors, trustees, officers, agents, servants and employees without claim for compensation and waive all claims related to or arising out of the publication and dissemination of the same.

_____ Initial

CONSENT FOR EMERGENCY TREATMENT
In the event that client should sustain any injuries while participating in activity or while on the premises of Reneu Health the client may be examined and treated by health care personnel, including examination at medical facilities. I voluntarily consent to such examination and treatment for the client, and I release and forever discharge Reneu Health, its directors, officers, staff, employees, contracted employees, agents and volunteers from any actions, suits, damages, claims, or judgments that may result from examination and treatment.

_____ Initial

MISSED SESSIONS
Twenty four hour (24) notice of cancellation is required for missed sessions. Sessions will be forfeited with less than twenty four hour (24) notice. In the instance a cancellation is made, Reneu Health will make every attempt to find the client another suitable time slot to make up for time lost. All cancellations must be made directly with the Director.
_____ Initial

SCHEDULE CHANGES
Due to the structured nature of the trial program and the Reneu Health permanent client schedule, Reneu Health is unable to accommodate any time and/or day schedule changes once the program has begun.
_____ Initial

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MEDICAL UPDATES
All clients are required to immediately notify Reneu Health of any changes in current medical condition. Such conditions include, but are not limited to blot clots, pressure sores, any skin issues, recent bone fractures and sprains, as well as any change in prescribed medications. Client will indemnify and hold harmless Reneu Health and all employees, volunteers, directors, officers, clients, and agents thereof from any claim, demand and/or cause of action of any nature whatsoever related to any injuries sustained as a result of undisclosed medical conditions or changes in prescribed medications.

_____ Initial

SKIN CONDITION DISCLOSURE
Proactive, preventative skin checks should be done daily. It is the client's responsibility to check his/her skin every day, especially after a training session. It is also the client's responsibility to inform the Reneu Health Director immediately if he/she has any skin irritation or skin breakdown that could potentially become a problem.

It is extremely important the client know his/her responsibility to disclose any skin issues to the Reneu Health Director.

Initial if you have read the above passage and understand it is your responsibility to notify the Reneu Health Director immediately if you notice any skin breakdowns.

_____ Initial

TERMINATION OF SERVICES.
Reneu Health reserves the right to terminate the service relationship with clients at any time, for any reason, with or without cause or notice and with no further liability to client. No oral or written statement shall limit the right to terminate the service relationship.

_____ Initial