



## Client Application

Send the following completed application to:

**Email:** [chriscorpuz@renew-health.com](mailto:chriscorpuz@renew-health.com)  
**Fax:** (619) 858-2210

**Mailing Address:**  
**PO Box 12817**  
**San Diego, Ca 92112**

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

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):

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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 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:

<u>Medication</u>	<u>Dosage mg/day</u>	<u>Type (Function)</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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

<u>Where</u>	<u>Duration (Months)</u>	<u>Results</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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

<u>Type</u>	<u>Duration (Minutes/Hours)</u>	<u>Frequency (How often)</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

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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

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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