

Pressing On Client Application Form

In an effort to provide the most safe and effective programs, we require all clients to complete this application. Information contained on this application will remain confidential.

Please complete the application and send via:

Fax: (210)877-2235

E-mail: info@pressingontx.com

Mail: 12001 Network Blvd, #314, San Antonio, TX 78249

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.

Contact Information

Client Name: _____ Date: _____

Address: _____ City: _____

State: _____ Zip: _____ Home Phone: _____

Cell Phone: _____ Email (Required): _____

Date of Birth: _____ Age: _____ Height: _____ Weight: _____

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/State: _____

Treating physician: _____ Date of Last Medical Examination: _____

In case of emergency, please notify:

Name: _____ Relationship: _____

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

Describe your physical abilities (Be as specific as possible, particularly with respect to your legs):

Upper Extremity: _____

Trunk (IE: Can you sit up?) _____

Lower Extremity: _____

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.

NOTE: All clients over 6 months post injury must obtain a bone density assessment and are required to submit a copy of the bone density report with the doctor’s interpretation before their first session at Pressing On. We do not interpret bone density reports.

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

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

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 (last 12 months): _____ (Other than SCI)

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: _____

Has your physician approved your participation in an intense exercise program? __YES __NO

NOTE: This is required prior to your first session at Pressing On.

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: _____

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

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 Pressing On to determine if medical clearance is needed before beginning an exercise program. I understand that if necessary, Pressing On 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 Pressing On while under the influence of any uncontrolled substance (e.g. marijuana) is strictly prohibited and will result in immediate termination of my participation in the program if detected.

Please print your name clearly: _____

Signature: _____ **Date:** _____

If under 18, name of parent or guardian: _____ **Relationship:** _____

Parent or guardian's signature: _____ **Date:** _____

Possible Start Date: _____

How did you hear about Pressing On?

- | | |
|--|---|
| <input type="checkbox"/> Referred by Doctor, Who? _____ | <input type="checkbox"/> Referred by Client, Who? _____ |
| <input type="checkbox"/> Online Search _____ | <input type="checkbox"/> Chat Room (IE: Care Cure) |
| <input type="checkbox"/> Referred by Pressing On Staff, Who? _____ | <input type="checkbox"/> Other _____ |

The information in this application is confidential and protected under the Privacy Act. The information is to be used solely by the staff of Pressing On in determining program eligibility. If you have received this information in error, please destroy the documents or mail the originals to Pressing On, 12001 Network Blvd. Suite 314, San Antonio, TX, 78249.

Billing Information

Billing Information (If different from the Client Application Form):

Name: _____ Phone #: _____ Billing Email: _____

Address _____

City: _____ State: _____ Zip Code: _____

Option 1: Pay by Check: Please make check payable to: Pressing On- A Spinal Cord Injury Research & Recovery Program

Print in memo section of check: Client's name

Send check to: Pressing On, Inc.
12001 Network Blvd. Suite 314, San Antonio, TX 78249

Option 2: Pay by Credit Card: MasterCard VISA

Card Number: _____ Expiration Date: (____ / ____)

Name on Card: _____

Skin Check Policy

Attention Clients:

For obvious reasons, proactive, preventative skin checks should be a daily priority. It is your responsibility to check your skin every day, especially after a workout. It is also your responsibility to inform your Lead Specialist immediately if you have a blister or skin breakdown that could potentially become a problem. This will allow your training team to design and implement a modified workout plan until your skin heals.

If your team is unaware of your skin problem, your workouts will continue as scheduled and your minor skin issue may eventually become a full blown pressure sore. If this occurs, it will definitely keep you out of this program and slow your recovery. Some of our clients have had to undergo surgery and have taken up to a year to heal.

It is extremely important to us that you know your responsibility as a client. We are here to help you but we must work as a team if we are to be successful. If you have any questions or concerns, please let us know.

I have read the above and understand that it is my responsibility to notify my Lead Specialist immediately if I notice any skin breakdowns.

Printed Name

Signature

Date