Beyond Therapy®
A SHEPHERD CENTER PROGRAM

2020 Peachtree Road, NW
Atlanta, GA 30309
404-350-7787

Enrollment Package

Please fill out as much information as possible, then print and mail to **Beyond Therapy - Atlanta, Attention Rebecca Washburn, 2020 Peachtree Road, NW, Atlanta, GA 30309**. You may also fax these forms to 404-367-1227, or scan the completed form and email to rebecca_washburn@shepherd.org.

All information given is personal and confidential. For assistance with filling out this form, call 404-350-7787.

Part I

First Name: Last Name: Middle Initial:

SSN#: Date Of Birth: Age:

Race: _____ ☐ Male ☐ Female Marital Status: _____

Street Address/P.O. Box:

City/State: Zip:

Country: Email Address:

Home Phone: Cell Phone: Work Phone:

Emergency Contact Name: Phone#:

Primary physicians name and address:

Have you seen a physician at Shepherd Center in the last 6 months? ___ Yes ___ No

If so, which Shepherd physician did you see? Dr.

Primary Diagnosis

___ **Spinal Cord Injury**

Cause of injury: _____ Date of injury: _____

Type of injury: _____ ___ complete ___ incomplete

Level of injury: _____ ASIA level: _____

___ **Brain Injury**

Cause of injury: _____ Date of injury: _____

___ **Stroke** Date of injury: _____

Primary Diagnosis continued on next page

____ **Other***

*If Other, please explain:

_____

Please list other associated injuries: (Fractures, Head injury, etc.)

_____

Functional Mobility (Complete this section if the person is 18 years or older).

Do you need assistance to do the following?

Yes	No		Yes	No	
____	____	Eat	____	____	Transfer to/from tub
____	____	Groom	____	____	Transfer to/from toilet
____	____	Bathe	____	____	Transfer to/from car
____	____	Dress	____	____	Transfer to/from floor
____	____	Transfer to/from bed			

What method do you use to get around?

☐ Power wheelchair ☐ Manual wheelchair ☐ Walking

What devices do you use to walk? _____

What distance are you able to walk? _____

Past rehabilitation: ____ Yes ____ No (If yes see below)

Name of Facility: _____ Date: _____

Shepherd Center: ____ Yes ____ No

Will you need any routine medical follow up during your time in the program? ____ Yes ____ No

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Currently receiving therapy: ____ Yes ____ No (If yes see below)

Name of Facility: _____

Frequency: _____ Start date: _____

Type of activities: _____

Goals:

_____

_____

Require assistance for:	Travel	Transfers	Wheelchair mobility
Yes	☐	☐	☐
No	☐	☐	☐

Please state your goals for the Beyond Therapy Program:

_____

What is your expected stay in the program? _____

Information taken by: _____ Date: _____

Part II Physician's Order and Activity Clearance Form

FOR PHYSICIAN USE ONLY

Patient Name: DOB:

☐ Physical Therapy evaluation and treatment

Physician's Signature: Date:

Physician's Name: Phone:

Office Address:

The patient named above is cleared to participate in the following interventions **(please check all that are acceptable interventions)**: This is important.

☐ Cycle ergometer using functional electrical stimulation (FES bike)
☐ Electrical stimulation for muscle contraction
☐ Body weight supported treadmill locomotor training
☐ Full weight bearing
☐ Partial weight bearing
☐ Aquatic therapy

The patient named above is cleared to participate in an intense exercise program including strength training and aerobic conditioning at least 3-5 days a week. Please list any physical limits/exclusions:

Physician's Signature: Date:

Part III Pre-Existing History Information

Directions: Mark an X next to any that apply. Please answer all questions.

Name: _____ Age: _____ Height: _____ Weight: _____ LBS

Is there a history in your family of the following (check each as it applies to a blood relative)?

____ Allergies
____ Anemia
____ Arthritis
____ Diabetes
____ High cholesterol
____ Epilepsy
____ Gout
____ Heart surgery
____ High blood pressure
____ Obesity
____ Sudden death

Father's Age: ____ if living: ____ if deceased: ____ Mother's Age: ____ if living: ____ if deceased: ____

Cause of death: _____ Cause of death: _____

Remarks: _____

Do you have or have you ever had any of the following? (Check all that apply)

____ Abnormal Chest X-Ray
____ Abnormal ECG
____ Anemia
____ Angina or Chest Pain
____ Arthritis
____ Asthma
____ Back Injuries
____ Back Pain
____ Badly Swollen Ankles
____ Cardiac Catheterization
____ Coronary Bypass
____ Diabetes
____ Dizzy/Fainting Spells
____ Emphysema
____ Epilepsy
____ Excessive Bleeding
____ Excessive Bruising
____ Fibromyalgia
____ Frequent Headaches
____ Gout
____ Guillain Barre Syndrome
____ Heart Attack
____ Heart Disease
____ Heart Murmur
____ Hernia
____ High Blood Pressure
____ High Cholesterol
____ Injuries to Arms
____ Injuries to Legs
____ Low Blood Pressure
____ Lung Disease
____ Multiple Sclerosis
____ Muscle Spasms
____ Nervous/Emotional
____ Problem
____ Paralysis
____ Phlebitis
____ Post-Polio Syndrome
____ Obesity
____ Pulmonary
____ Recent Bronchitis
____ Recent Pneumonia
____ Rheumatic Fever
____ Shortness of breath
____ Sickle cell anemia
____ Skipped heart beats
____ Spinal Cord injury
____ Stroke
____ TBI/ABI
____ Transient blindness
____ Transverse myelitis
____ Tuberculosis

Comments on any of the above, or please explain any medical problems not listed:

_____

_____

_____

Date of last complete medical exam: _____ Were the results normal? ____ Yes ____ No

If no, explain: _____

What is your resting blood pressure? ____ mmhg ____ Unknown

What is your resting heart rate? ____ Beats/min ____ Unknown

What is your cholesterol level? ____ mg% ____ Unknown

Have you ever had an exercise ECG? ____ Yes ____ No Date: _____

Results: _____

List any medications or drugs you currently are taking:

_____

_____

List any drug allergies you have:

_____

_____

Name of Physician(s):

Physician's Phone: Physician's Fax:

PAR-Q & YOU

For most people, physical activity should not pose any problem or hazard. Par-Q has been designed to identify the small number of adults for whom physical activity might be inappropriate or those who should have medical advice concerning the type of activity most suitable for them.

Common sense is your best guide in answering these questions. Please read them carefully and check Yes or No opposite the question as it applies to you.

Yes	**No**	
____	____	1. Has your doctor ever said you have heart trouble?
____	____	2. Do you frequently have pains in your heart and chest?
____	____	3. Do you often feel faint or have spells of severe dizziness?
____	____	4. Has a doctor ever said your blood pressure was too high?
____	____	5. Has your doctor ever told you that you have a bone or joint problem such as arthritis that has been aggravated by exercise or might be made worse with exercise?
____	____	6. Is there a good physical reason not mentioned here why you should not follow an activity program even if you wanted to?
____	____	7. Are you over the age of 65 and not accustomed to vigorous exercise?

Do you know of any medical reason that might make it dangerous or unwise to participate in vigorous exercise?

____ Yes ____ No

If yes explain: _____

_____

Do you currently smoke? ____ Yes ____ No If yes, how many a day? _____

If no, did you ever smoke? ____ Yes ____ No If yes, how long ago did you quit? _____

Are you pregnant? ____ Yes ____ No ____ N/A

Are you less then 5 weeks post partum? ____ Yes ____ No

Are you presently in an exercise program? ____ Yes ____ No

If yes, in what kind of activities do you engage? _____

How often (i.e., 3x/week)? _____

For what period of time (i.e., 30 min., 1 hour)? _____

Do you have muscle spasms? ____ Yes ____ No

If yes, do they limit your ability to transfer? ____ Yes ____ No

If yes, do they limit your ability to use exercise equipment? ____ Yes ____ No

Do you currently have a skin breakdown? ____ Yes ____ No

If yes where? _____

Are you prone to skin breakdown? ____ Yes ____ No

Does your level of disability necessitate you to have adapted equipment for exercise? ____ Yes ____ No