



MOVEMENT REVOLUTION

Client Information

Welcome to Movement Revolution! We are excited to welcome you into our program.

To begin, please complete the following documents:

1. Member Information Form & Welcome Policies
2. Physician's Medical Release
3. Questionnaire
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 _____

Health Information

Primary disability/injury/condition: _____

Date of diagnosis ____/____/____

Primary Doctor _____ Hospital _____

Specialist (Neurologist/Cardiologist ect): _____

Primary Symptoms (brief description)

Balance _____

Postural Instability _____

Vision Impairment _____

Shortness of breath _____

Fatigue _____

Rigid/Tight Muscles _____

Other _____

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

Medications List:

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 heart disease? Yes No

Do you have, or have a family history of **high blood pressure** or **heart disease**, high **cholesterol**, and/or **seizures**? (If applicable: circle) and explain:

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

Do you use a walker or wheelchair, or do you need assistance walking? 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 _____