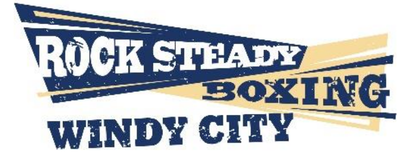
MOVEMENT
REVOLUTION



Client Information

Welcome to Movement Revolution! We are pleased to welcome you into our program.
To begin, please complete the following documents:

1. Member Information Form & Media Release
2. Physician's Medical Release
3. Personal Waiver and Release of Liability
4. PDQ-39 Questionnaire
5. UPDRS I/II
6. Falls Efficacy Scale

Date ____/____/____ Age__________ Gender(circle) Male or Female

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 ___________________________________

Parkinson's Information

Date of diagnosis ____/____/____

Neurologist ____________________ Hospital____________________

Symptoms (brief description)

Tremor____

Postural Instability ____

Balance ____

Weakness ____

Fatigue ____

Rigidity ____

Freezing____

Blood Pressure ____

Have you undergone Deep Brain Stimulation? (circle) Yes No If yes, date:___________

During the past month I have fallen…… (circle one)

Never 1-2 Times About once a week Everyday Multiple times a day

Medications List- Please list **name** and **dosage**: (If you have a list, we can copy it.)

____

____

____

Timing of Medications: ___________________________

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 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

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 ____________________

What other exercise activities to do regularly (at least 2-3x a week) participate in?

(circle all that apply)

Walking Biking Jogging Yoga Pilates Zumba Other______ None

Have you been diagnosed with any other medical problems we should be aware of?

____

____

Are there any activities you enjoy that you've stopped since being diagnosed?

____

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 ______________________________