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. Stroke Impact Scale
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 _____

Diagnosis Information

Date of diagnosis ____/____/____

Primary Doctor seen since your Stroke _____

Hospital_____

Symptoms (brief description)

Hemiparisis_____

Weakness _____

Vision Impairment _____

Shortness of breath _____

Fatigue _____

Speech Impairment _____

Other _____

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

Do you use an assisted device (circle one)? Yes No

If yes, device(s) used: _____

List of Medications:

_____ _____ _____

_____ _____ _____

_____ _____ _____

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

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 _____