



## SLI Neuro-Wellness Center: Neuro-Fit Assisted Exercise Program Registration

Date Completed: \_\_\_\_\_ Completed by: \_\_\_\_\_

Participant Information			
Participant Name:	Date of Birth:		Gender:
Home Street Address:	Town:	State:	Zip:
Phone:	E-mail:		
Emergency Contact Information			
Name:	Phone:	Relationship:	
E-mail:			

### Participant Billing Information

Does the participant agree to pay a fee of \$15 per 1-hour session?\*  Yes  No

\*Note: Fee may be negotiated on a sliding scale for those in need. Please reach out to the Brain Injury Wellness Center manager.

Please indicate the agreed amount to be paid per session, if not \$10: \_\_\_\_\_

Does the participant manage his/her own finances?  Yes  No

If no, name of representative payee: \_\_\_\_\_

Email: \_\_\_\_\_ Phone: \_\_\_\_\_

Billing Address (If different than home address):

\_\_\_\_\_  
Street Address Town State ZIP

Please indicate with your signature below that you, the participant, agree to the above information regarding billing for the SLI Brain Injury Wellness Center exercise program.

Signature

\_\_\_\_\_ Date: \_\_\_\_\_

### Participant Health Information

Type of Brain Injury (if applicable):		Date of Injury:	
Other Relevant Diagnoses (if applicable):		Allergies:	
Current Medications:		Resting Heart Rate and Blood Pressure:	
		HR:	BP:
Height:	Weight:		

1) Do you have a pacemaker/cardiac defibrillator?  YES  NO

If yes, indicate type of implant \_\_\_\_\_

Have you had heart surgery before?  YES  NO

If yes, indicate type of surgery \_\_\_\_\_

2) Are you restricted from performing certain tasks/activities?  YES  NO

If yes, indicate restricted activity/task(s) \_\_\_\_\_

3) Are you currently taking medications for a chronic medical condition?  YES  NO

If yes, what is the name of medication? \_\_\_\_\_

4) Type of assistive device used for walking (if applicable):

Quad cane  Standard crook cane  Gait belt with assist  Crutches  Standard walker  Rolling walker  
 Wheelchair

5) Do you require assistance with any of the following? (check all that apply):

Transfer: Bed to chair  Transfer: Chair to Chair  Laying down to Standing  Bathroom

If yes, indicate level of assistance needed:

One person assist  Two person assist  Assistive Device (indicate) \_\_\_\_\_

6) Do you have a history of frequent falls?  Yes  No

If yes, when was your last fall? \_\_\_\_\_

7) Do you have a history of seizures or seizure disorder?  Yes  No

8) Does the participant have a Do Not Resuscitate (DNR) order in place?  Yes  No

Please use this space to make any other comments regarding the participants' ability to exercise safely:



# SLI NEURO-WELLNESS

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7 Oakland St.  
Lexington, MA 02420  
(781) 274-8711  
www.supportivelivinginc.org

## Physician Consent for SLI Brain Injury Wellness Center Exercise Program

Your patient, \_\_\_\_\_ D.O.B: \_\_\_\_\_, has expressed interest in participating in the Supportive Living, Inc. Brain Injury Wellness Center Exercise Program held at Douglas House in Lexington, MA. The Exercise Program is designed to promote an overall healthier lifestyle, improve mobility, promote therapeutic exercise and support independence. A comprehensive medical and activity questionnaire will be completed, followed by a complete fitness assessment. Participants will be instructed and supervised during all exercises. Exercises will include cardiovascular, resistance, flexibility, and balance training. The exercises and intensity of the program will be modified to fit each individual patient's needs, and health goals.

Please list any modifications, comments, or concerns you may have for testing and exercise:

If your patient requires HR or other parameters monitored during exercise, please specify:

Please indicate with your signature below that your patient is medically cleared to participate in the fitness program.

Physician Name: \_\_\_\_\_ Date: \_\_\_\_\_

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_



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## SLI Neuro-Wellness Center: Release and waiver for Participants, Interns, and Volunteers

In consideration of the undersigned being on premise of voluntarily participating in the independent program at the SLI Wellness Center (SLIWC), the undersigned, individually and on behalf of their undersigned heirs, representatives and next of kin, agrees to:

1. release, waive and discharge, and to indemnify and hold harmless SLIWC and its employees, volunteers and affiliates from all loss, expense and liability for injury, death and damages to the person or property of the undersigned, whether caused by the negligence of SLIWC, its employees, volunteers, or affiliates, or otherwise while using SLIWC facilities; and
2. assume full responsibility for risk of injury, death of damages to the person or property of the undersigned, whether caused by negligence of SLIWC, or its employees, volunteers or affiliates or otherwise while using SLIWC facilities.

I understand the program is not a therapy program, nor a substitute for medical treatment. I do represent and warrant that I have been advised to seek consultation from a doctor about whether I can safely participate in this program and whether there are precautions or limitations to my participation.

The facility reserves the right to limit participation of individuals when criteria are not met or the safety of participants or staff is compromised.

The undersigned acknowledges that no oral or written statements or agreements contrary to this document have been made to the undersigned and that this document supersedes any and all prior statements and agreements with SLIWC. This document may only be changed in a writing executed by SLIWC.

The agreements in the document shall be continuing and shall not terminate without the prior consent of SLIWC.

The undersigned has read, understands and voluntarily signs this document.

Print Name \_\_\_\_\_ Date \_\_\_\_\_

Signature \_\_\_\_\_

### Personal Care/Hygiene

I understand that SLIWC is not responsible for personal care or hygiene of the participant throughout the one-hour Neuro-Fit session. If the participant needs assistant, the appropriate caretaker will be present during the exercise session.

Signature \_\_\_\_\_

### Media/Photo Waiver

I authorize Supportive Living, Inc. to publish photographs, recordings, or videotapes in which I appear to be used for public view. Media use could include, but is not limited to: television, newspapers, internet, advertisements, and other medium.

Signature \_\_\_\_\_