SPECTRUM
COMMUNITY SERVICES, INC.
2621 Barrington Ct., Hayward CA 94545

Date_____ Site_____

NEW CLIENT REGISTRATION
Fall Risk Reduction Program
Informed Consent

The risks and benefits of this exercise program have been reviewed and explained to me. I understand and confirm that I will choose the level of activity that will not harm me. In consideration of my participation in the Fall Risk Reduction Program that includes: fall prevention skill building, exercise and education, I hereby release SPECTRUM COMMUNITY SERVICES, INC., its officers, employees or agent from any liability for my personal injury, or otherwise arising out of, or in any way connected to my participation in this program.

_____
Name (please print)

_____
Signature

Male____ Female____ Birthdate _____ Age _____

Address _____

City_____ Zip code _____

Phone (____)_____ Cell phone (____)_____

IN CASE OF EMERGENCY, PLEASE NOTIFY

Name _____

Phone Number _____

Relationship _____

Are you the head of your household? YES_____ NO_____

What is your primary language?_____

Income (check one):

- ☐ Below $19,000
- ☐ $ 20,000 - $ 32,999
- ☐ $ 33,000 - $ 50,000
- ☐ Over $51,000

Check ALL that apply:

- ☐ Asian
- ☐ African American
- ☐ Caucasian
- ☐ Amer. Indian or Alaska Nat.
- ☐ Nat. Hawaiian or Other Pac. Isl.
- ☐ Hispanic

Other_____

ACTIVITY LEVEL

Rate on a scale of 0 to 4 the level of help you need in the following areas;
0 being no help:

Function	Need for assistance	Function	Need for assistance
Eating	0 1 2 3 4	Shopping	0 1 2 3 4
Bathing	0 1 2 3 4	Managing finances	0 1 2 3 4
Dressing	0 1 2 3 4	Using a telephone	0 1 2 3 4
Using the toilet	0 1 2 3 4	Light housework	0 1 2 3 4
Getting in/out of bed	0 1 2 3 4	Heavy housework	0 1 2 3 4
Walking	0 1 2 3 4	Taking medications	0 1 2 3 4
Preparing meals	0 1 2 3 4	Using transportation	0 1 2 3 4

Assistive devices used: _____
(cane, walker, hearing aid, glasses, wheelchair, etc…)

HEALTH ASSESSMENT

	YES	NO
Do you have any unusual pain? Where?	☐	☐
Have you ever broken or fractured a bone? What bone?	☐	☐
Do you get chest pains while at rest or during exertion? Is your doctor aware of the condition?	☐	☐
Have you ever had a heart attack? When?	☐	☐
Have you ever had a stroke? When?	☐	☐
Do you experience shortness of breath?	☐	☐
Do you have any ulcerated wounds/cuts on your feet that do not heal?	☐	☐
Do you smoke? Did you at any time smoke?	☐	☐
Have you fallen in the last 12 months?	☐	☐

In general, how would you rate your health?

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor ☐ Very Poor

HEALTH INFORMATION

Allergies (Medication, Foods, Insect Bites, Other) _____

_____

Current Medications:

Name	Purpose

MEDICAL CONDITIONS

DO YOU HAVE OR HAVE YOU EVER BEEN TREATED FOR:

Arthritis	Yes ☐	No ☐
Asthma	Yes ☐	No ☐
COPD	Yes ☐	No ☐
Depression	Yes ☐	No ☐
Cancer	Yes ☐	No ☐
Diabetes	Yes ☐	No ☐
Eye Condition	Yes ☐	No ☐
Heart Attack	Yes ☐	No ☐
Angina (chest pain)	Yes ☐	No ☐
Do you have a pacemaker?	Yes ☐	No ☐
Hepatitis	Yes ☐	No ☐
High Blood Pressure	Yes ☐	No ☐
Movement Disorders	Yes ☐	No ☐
Osteoporosis	Yes ☐	No ☐
Parkinson's Disease	Yes ☐	No ☐
Seizures	Yes ☐	No ☐
Stroke	Yes ☐	No ☐
Tuberculosis	Yes ☐	No ☐
Ulcers	Yes ☐	No ☐

Other_____

Please list all medical insurance under which you are covered:

_____

_____

The above information is to the best of my knowledge complete and accurate.

Signature_____ Date_____

PLEASE RETURN THIS FORM AS SOON AS POSSIBLE

Thank you for participating in the Fall Risk Reduction Program

sb 12/2014