# ABLE BIONICS USA
# CLIENT INFORMATION FORM

Please fill out the following completely and accurately.

**Date:**

## EXOSKELETON AND/OR GALILEO CLIENT

Name: ____________________

Age: ________ Date of Birth:______/______/______

Address: ____________________

____________________

____________________

Home phone: ____________________

Cell phone: ____________________

Email address: ____________________

Disability: ____________________

Disability details: ____________________

____________________

____________________

Height: ____________ Weight:____________lbs.

Primary language spoken/understood: ____________

Have there been any seizures in the last two years? ________

Is the client ambulatory? Yes________No ________

What are the client's primary means of mobility (i.e., power wheelchair, manual wheelchair, cane, walker, etc.)?

1. ____________________
2. ____________________
3. ____________________

## PARENT/GUARDIAN INFORMATION

(Necessary for clients under 18 years of age)

Name:____________________

Relation:____________________

Address: ____________________

____________________

____________________

Home phone: ____________________

Cell phone: ____________________

Work phone: ____________________

Email address: ____________________

Primary language spoken/understood: ____________

## EMERGENCY CONTACT INFORMATION

(if different from Parent/Guardian)

Name:____________________

Relation:____________________

Home phone: ____________________

Cell phone: ____________________

Work phone: ____________________

Primary language spoken/understood: ____________

## PHYSICIAN INFORMATION

Name:____________________Location (City/State): ____________________

Office phone:____________________ Home phone: ____________________

**To be completed by the client or parent/guardian – please answer all questions that pertain to the client.**

Have you sustained a spinal cord injury? ☐ Yes ☐ No

If not, please indicate other diagnosis and cause ______________________________

Level of SCI: ____________________ Incomplete Complete

Date of injury: __________________ Cause of injury: ______________________________

______________________________

Surgery date and procedure ______________________________

Have you sustained a traumatic brain injury? ☐ Yes ☐ No

If yes, please describe ______________________________

What are your primary means of mobility (i.e., power wheelchair, manual wheelchair, cane, walker, etc.)?

______________________________

Are you able to walk? ☐ Yes ☐ No

If so, do you use braces? ☐ Yes ☐ No

What type of assistive device do you use (i.e., crutches, walker, AFO, KAFOs)? ______________________________

Do you need assistance with any transfers to and from your wheelchair? ☐ Yes ☐ No

If so, how much assistance is needed? ______________________________

Have you ever had a bone density scan/DEXA scan? ☐ Yes ☐ No

If so, when and what were the results? ______________________________

Have you ever been diagnosed with osteopenia or osteoporosis? ☐ Yes ☐ No

Have you ever fractured a bone? ☐ Yes ☐ No

If so, **when and what** bone did you fracture? ______________________________

Do you have full strength in both your arms? ☐ Yes ☐ No

If no, what is limited (i.e., grip, shoulder strength, etc) ______________________________

Any history of shoulder injuries (i.e., dislocation, rotator cuff tear etc.)? ☐ Yes ☐ No

If yes, please describe what and when ______________________________

Any history of, or current, orthopedic injuries pertaining to back, hips, knees, shoulders, etc.? ☐ Yes ☐ No

If yes, please describe ______________________________

______________________________

Do you have heterotopic ossification or a history of H.O.? ☐ Yes ☐ No

If yes, where was/is it? ______________________________

**To be completed by the client or parent/guardian – please answer all questions that pertain to the client.**

Are you taking any medications for pain or any other conditions (i.e., spasticity or nerve pain)? ☐ Yes ☐ No

If yes, what are the side effects and how often do you take them? ______________________________

List of medications

1. ____________________
2. ____________________
3. ____________________
4. ____________________
5. ____________________

How long has it been since you stood upright? ______________________________

Do you ever get lightheaded or dizzy when you stand? ☐ Yes ☐ No

Do you have a standing frame? ☐ Yes ☐ No

If so, how often and for how long do you use it? ______________________________

If you experience autonomic dysreflexia, do you know when it is happening? ☐ Yes ☐ No

Please describe usual presentation and trigger ______________________________

Do you currently have any open wounds (pressure sores, abrasions, cuts etc.) or a history of wounds? ☐ Yes ☐ No

If yes, where and/or when? ______________________________

Do you have a visual impairment? ☐ Yes ☐ No

Do you have a hearing impairment? ☐ Yes ☐ No

OTHER: Please describe any other disability, disease or disorder that we should be aware of ______________________________

______________________________

______________________________

Client's Signature: ______________________________ Date: ______________________________

Client's Name (Please print): ______________________________

Parent/Guardian Signature: ______________________________ Date: ______________________________

Parent/Guardian Name (Please print): ______________________________