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): _____