

Member Information

Welcome to Rock It Out, Inc.

We are pleased to welcome you into our program.

To begin, please complete the following documents:

1. Member Information Form
2. PDQ-39 Questionnaire
3. 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 Rock It Out? (circle) Referral / Media /Website / Other _____

Emergency Contact Information

Name _____

Relationship to applicant _____

Address _____

City _____ Zip Code _____

Home phone _____

Cell phone _____

Email _____

Parkinson's Information:

Estimated date of diagnosis ____/____/____

Which symptoms are you experiencing? (check all that apply)

Tremors - if yes, which side is most affected? RIGHT LEFT BOTH

Postural changes

Loss of balance in the last year

Slowness of movement

Vision impairment

Difficulty concentrating or staying focused

Fatigue

Depression

Do you take medicine for Parkinson's? If yes, please list:

Other Health Questions

Do you: (check all that apply)

Use a walker, wheelchair or other assistive device

Have Deep Brain Stimulation (DBS)

Feel dizzy or unsteady with sudden movements

Have difficulty getting down or rising from a seated or lying position

AHA/ACSM Health/Fitness Facility Pre-Participation Screening Questionnaire

History: (check all that apply)

You have had:

- A heart attack**
- Heart surgery**
- Cardiac catheterization coronary**
- Angioplasty (PTCA)**
- Pacemaker/implantable cardiac defibrillator**
- Rhythm disturbance**
- Heart valve disease**
- Heart failure**
- Heart transplantation**
- Congenital heart disease**
- Other heart condition (specify) _____**

Symptoms:

- You experience chest discomfort with exertion**
- You experience unreasonable breathlessness**
- You experience dizziness, fainting or blackouts**
- You take heart medications**

Other health issues:

- You have diabetes**
- You have asthma or other lung disease**
- You have burning or cramping sensation in your lower legs when walking short distances**
- You have burning or cramping sensation in your lower legs when short distances**
- You have musculoskeletal problems that limit your physical activity**
- You have concerns about the safety of exercise**
- You take prescription medication(s)**
- You are pregnant**

(FOR OFFICE USE ONLY)

Notes and questions for test administrator

What symptoms of Parkinson's are you experiencing in your daily life?

Have you been diagnosed with any other medical problems we should be aware of?

What do you wish to gain from joining Rock It Out?

Do you have questions or concerns about the program before we get started?

Additional administrator notes: _____

(Administrator to explain Media Release)

Media Release

I _____ (member name) allow Rock Steady Boxing Cleveland/Rock-It-Out Inc. to publish or broadcast my image/likeness and/or name for promotional purposes associated with Rock Steady Boxing.

Signature _____ Date _____