Developmental Fitness Company
INCLUSION • DIRECTION • COMPASSION • CHALLENGE

PARTICIPANT INTAKE FORM

GENERAL INFORMATION

Name_____

Address_____

City_____State_____Zip_____

Phone_____Cell Phone _____

Gender_____Date of Birth _____

Email _____

Support Coordinator _____Support Coord Email _____

Size shirt _____ Where would you like our services ? ____ Home ____Gym ____Community ____ All

Member of fitness center ? _____Gym Name and Location _____

EMERGENCY CONTACT INFORMATION

Parents/Guardians_____

Address_____

City_____State_____Zip_____

Phone_____Cell Phone _____

Second Cell Phone_____Email_____

Secondary Email _____

INSURANCE INFORMATION

Company _____Policy Number _____

Developmental Fitness Company, LLC
PO Box 1025
North Wales, Pa 19454

Phone: 215-527-2475
E-mail: info@developmentalfitness.com
Website : www.developmentalfitness.com

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FAMILY HISTORY

Please mark if there is any family history of the following:

Hypertension_____Heart Attack_____Stroke_____Cancer_____Diabetes_____

Are both parents living ?_____

If not what cause and what age did either decease ? _____

PERSONAL HEALTH HISTORY

_____Abnormal EKG_____Seizures_____Phlebitis____Asthma_____Kidney Issues___Pregnancy___Cancer

_____Emphysema_____Embolism____Hearing____Autism_____Arthritis____Hernia_____Cardiac Issues

_____Diabetes_____Cholesterol___Thyroid_____Mental Heath____Vision Issues_____Hypertension

_____Learning Disability_____Blood Sugar_____Nerve Damage___Brain Injury_____Respiratory Issues

_____Neuromuscular_____Gait_____Skin Issues____Falls

_____Other_____

_____

_____

_____

Please check if you have any complications with the following:

_____Hand_____Wrist_____Ankle____Foot_____Shoulder___Elbow____Arm_____Back____Hips_____Legs

_____Knee_____Neck_____Head_____Fingers___Toes_____Abdomen___Pelvis ___

_____Other :_____

_____

_____

_____

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THERAPY CONCERNS

Are you or have you been under the care of Physical or Occupational Therapist for any condition ? _____

If yes, can we call them ?_____Therapist Name_____Therapist Phone _____

Do you have a physical disability ?_____If yes, please name _____

Do you require assistive devices ?_____If yes, please list _____

Do you have any limitations of movement ? If yes, please describe _____

Has your doctor ever contraindicated exercise for you ?_____ If yes please explain:

_____

_____

_____

_____

Do you have any conditions that could be aggravated by exercise ?_____If yes please explain

_____

_____

_____

_____

Please list all medications that you are currently taking for any condition:

Name	Dosage	Taken to control	Time Taken

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PHYSICIANS RECOMMENDATION FORM

Physicians Name _____

Address _____

City _____ State _____ Zip _____

Phone _____ Fax _____

Email _____

Please check off for those participating in our therapeutic fitness program

_____I recommend participation without limitation

_____I recommend participation with limitations _____

_____I do not recommend participation.

Additional Comments or Notes

_____

_____

_____

Physicians Signature _____

Date _____

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AVAILABILITY

Please let us know when you are available for our services below. We seek out trainers in your immediate area all of which have different schedules and availability. We ask that you can be as flexible and adaptable as possible. We seek to accommodate everyone availability as best we can. Place an X in those boxes that work for you.

	8 AM	9 AM	10 AM	11 AM	12 PM	1 PM	2 PM	3 PM	4 PM	5 PM	6 PM	7 PM
Sun												
Mon												
Tues												
Wed												
Thur												
Fri												
Sat												

As we try to accommodate schedules and availability of both trainers and participants please let us know of any special scheduling circumstances.

_____
_____
_____
_____

Is there a request for a specific gender trainer ? _____ Male _____ Female _____ No preference

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Community Participation Support

Please list up to 10 things that you have an increased interest in

_____
_____
_____
_____

Please list activities that do not interest you

_____
_____
_____
_____

What type of physical activities do you enjoy ?

_____
_____
_____
_____

Favorite Sports _____ Favorite Teams_____

Favorite Indoor Activity _____ Favorite Outdoor Activity _____

Special Notes on Supervision Needs ?

_____
_____
_____
_____
_____
_____

Any additional information ?

_____
_____
_____
_____
_____
_____

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INFORMED CONSENT

I,_____(Name), do hereby voluntarily contract and enroll in a program of physical activity and community integration including but not limited to therapeutic exercise, neuromuscular reconditioning, manual stretching, cardiovascular conditioning, sports skills training, balance and postural conditioning, and so forth, offered by Developmental Fitness Company, LLC. I do hereby acknowledge that I have been informed of the need and the requirement for a physicians approval and/or prescription for my participation in an exercise program. I acknowledge that I have either had a physical examination conducted by a licensed medical physician with their permission/ recommendation/prescription to participate. I also understand that no Developmental Fitness service will rendered until such requirements of physicians approval/recommendation/prescription is met. I hereby represent and inform Developmental Fitness Company, LLC and it representatives, that I have accurately completed all health history questions. I acknowledge and understand the risks associated with an exercise program. I do hereby assume this risk by entering into this exercise/therapy program. I also understand and acknowledge that Developmental Fitness Company will not be responsible or liable for issues resulting from physical activity done outside the direct supervision of a Developmental Fitness Company Program Representatives. With the understanding of these said elements, I therefore, voluntarily consent to engage in the Developmental Fitness Company program of (please check):

_____Therapeutic Fitness

_____Community Participation Supports

I understand that information obtained in this written document or during the implementation of said program will be treated as privileged and confidential at all times and will consequently not be released without the expressed written consent of the undersigned and the representors. I understand the contract that I am about to enter. I acknowledge that I understand this document in its entirety or that it has been communicated or read to me if I have been unable to read or understand its form. I hereby consent to the rendition of services and procedures as explained herein by the Developmental Fitness Company program. I agree furthermore that facilities in which I am a member Developmental Fitness staff can assist as defined support staff. I also agree to abide by all facility policies regarding the privilege of usage of the facility where services are rendered.

Signature _____Date _____

Parent/Guardian Signature _____Date _____

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At Developmental Fitness Co, it is our duty as a company to foster rights for the individuals we serve.

An individual has the right to civil and legal rights afforded by law, including the right to vote, speak freely, and practice the religion of his choice or to practice no religion.
An individual may not be discriminated against because of race, color, creed, disability, religious affiliation, ancestry, gender, gender identity, sexual orientation, national origin, or age.
Participants in our program have the right to be free from and to report abuse, neglect, and exploitation and as well as voice complaints or concerns about treatments or services.
An individual shall be treated with dignity and respect.
An individual has the right to make choices and accept risks.
An individual has the right to refuse to participate in activities and supports.
An individual has the right to control the individual's own schedule and activities.
An individual has the right to privacy, access and security of person and personal possessions.
An individual has the right to choose a willing and qualified provider.
An individual has the right to choose where, when, and how to receive needed supports.
An individual has the right to assistive devices and support to enable communication.
An individual has the right to participate in the development and implementation of their ISP.
An individual has the right have access to food at any time.
An individual has the right to eat within the home or community during the provision of services
An individual has the right to negotiate their own choices.
An individual's rights shall be exercised so that another individual's rights are not violated.
An individual has the right to access to the community
An individual has right to facilitate and make accommodations to visit any other individuals.
Participants have the right to participate in community activities of their choice.
Participants have the right to the same degree of community access and choices
Participants have the right to explanation of these rights.
Please acknowledge this information by signing below.
Thank you.

I have been informed of my rights pertaining to the delivery of services with Developmental Fitness.

Signature _____ Date _____

Parent/Guardian Signature _____ Date _____

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Welcome to the Developmental Fitness Family!

Developmental Fitness has a passion for assisting those with developmental or intellectual disabilities reach their goals, dreams and aspirations. Developmental Fitness Company serves as their partner to a greater well-being through physical fitness. Throughout the course of our training, we also help them take a step higher in achieving their personal level of independence, learning how to make life choices, and becoming an important member of the community

Who we are

All of our staff have certification or degree or outright licensure in a health related and exercise based field. All of our staff have all necessary background checks as well as CPR and First Aid certification. All of our trainers are independent contractors and all possess a background and experience in working with those with developmental disabilities.
We seek to find the right person first always that fits with our mission.

How we do it

All of our staff are regulated and defined as a direct support professional. We are able to provide services at your house or any community location. Most importantly, if you have a membership to a fitness center or gymnasium we are able to accompany the participant without issues as a direct service professional to the participant. This is covered under the American with Disabilities Act (ADA).

How to get started

Please fill out the referral packet in its entirely. We utilize all this information to connect with you with the best staff in your area. The Physician Recommendation must be competed and signed in order to start services. Our services are covered under waiver funding through ODP. Please indicate to your support coordinator how many hours per week that you would like of our services and once approved we will connect you with one of our staff to start services.

Make sure to visit our website

Many questions can be answered on our website at

www.developmentalfitness.com

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