

Shirley Ryan AbilityLab Adaptive Sports & Fitness Program Participant Intake Form

I am interested in Participating in:	Functional Fitness Program	Adaptive Sports Program	
First Name:	Last Name:		
Street Address:	City:	State:	Zip:
Cell Phone: ()	Home or Work Phone	: ()	
Date of Birth:/	Email:		
Military Veteran: YES NO	We never sell or share your email addro program information, appointment remi	ess. By providing your email, you opt in to re inders and other direct communication.	eceiving important
	Check box if you wish to opt out of re	ceiving newsletters and program updates.	
Diagnosis:Amputation: Level: Cerebral PalsyCOPDOther: (Explain disability)	Head Injury/TBI Multiple Sclerosis Parkinson's disease	Spinal Cord Injury: Level Stroke Visual Impairment	Complete/Incomplete
Is disability: Congenital (present	t at birth) YES NO or	Acquired or diagnosed on th	nis date: / /
	,		
•	r-the-counter)		
Please indicate if you have:			
Seizures YES NO How many	y in the past 12 months:	Date of most recent seizure:	//
Diabetes YES N Heart Disease Other: YES N		Heat Related Problems High Blood Pressure	YES NO YES NO
I am currently receiving outpatient If yes, are you receiving physical th	t physical therapy: nerapy at a Shirley Ryan AbilityLab lo	YES NO YES NO	
	AbilityLab, Adaptive Sports and Fitness sport team representatives, to seek me		
Signature of participant:		Dat	e:/
Signature of Theranist (If applicable)			e: / /