FSWC Québec

Client Application Form

Afin dIn an effort to provide the most safe and effective programs, FSWC Québec requires potential clients to complete this application. Information contained on this application will remain confidential.

Please complete this application, save it and send it to:

admission@fswcquebec.ca

After your application is reviewed, our office will contact you by e-mail or by phone. **Please note that the completion of this application does not guarantee your participation in our program.**

* Required fields

Your choice of the program (*):

- ○ **Activity-based therapy program and Functional Electrical Stimulation (FES) bike programs**

  Admission priorities: People with spinal cord injuries who request an intensive program of a minimum of 6 hours/week for 3 months or more will be given priority as this program is specifically designed for this clientele. Depending on the availability of our human and material resources, we accept clients with different neurological conditions and clients who wish to follow the program less intensively.

- ○ **Only the Functional Electrical Stimulation (FES) bike program**

Note :
Please understand that our cost to provide the Activity-based therapy program and the functional electrical stimulation bike program is $125/hour for the year 2022.

However, it is possible to apply preferential service fees thanks to our donors.

The service fee for **Quebec residents** is currently set at $40 per hour, thanks to donations from mostly Quebec donors.

You are required to present proof of Quebec residency by showing your valid RAMQ card or driver's license at your initial consultation in order to benefit from this special Quebec resident fee.

The service fee for **residents of Canada (outside of Quebec)** for the Activity-based therapy program is set at $90/hour and the fee for the SEF Cycling Program is set at $40 per 45 minute session. You are required to show proof of residency in Canada (other than Quebec: Canadian passport or permanent residency card) in order to benefit from our service rate established specifically for residents of Canada (outside of Quebec).

The service fee for the Activity-based therapy program for **residents outside of Canada** is currently set at $120 per hour. The service fee for the functional electrical stimulation bike program for residents outside of Canada is currently set at $40 per 45 minute session.

Client Information: Last Name(*):_____ First Name(*):_____
Date of Birth (YY/MM/DD) (*) :_____ Weight kg(*) :_____
Height m(*) :_____ Gender: ◯ Male ◯ Female
Address(*)_____
City (*) :_____ Province (*) :_____ Postal Code (*) :
Email (*):_____
Home Phone :_____ Cell Phone: _____
Do you have insurance coverage (*): 1) for Physiotherapy Technologist services ◯ yes ◯ no
2) for Kinesiologist services ◯ yes ◯ no

Medical Information:
Neurological Condition/Diagnosis (Check all that apply and enter the date of injury or diagnosis) (*)

☐ Spinal Cord Injury Date :_____ ☐ Multiple Sclerosis Date :_____
☐ Acquired Brain Injury Date :_____ ☐ Stroke: Date : _____
☐ Spinal Tumor Date: ☐ Parkinson's disease Date :_____
☐ Cerebral Palsy ☐ Autre (veuillez expliquer) :

_____
_____

Is there anything else we should know about your condition? (i.e. if Cerebral Palsy, Stroke, MS what type?) (*)

_____
_____
_____

If Spinal Cord Injury or Acquired Brain Injury: What was the cause of injury? (*)

_____
_____

Level of Injury(*): _____ ◯ Complete ◯ Incomplete
Asia Level/Score: ◯ A ◯ B ◯ C ◯ D

Date of last medical examination (YY/MM) (*):_____

Types of exercise done during the rehabilitation program in the public healthcare system, if any (standing, gait training, etc.)

_____

_____

_____

Date last attended rehabilitation (YY/MM) (*) : _____

Results of rehabilitation (*) :

_____

_____

_____

Any surgical hardware/implants (rods, screws, plates, shunts, pumps, deep brain stim, etc.)
Please indicate type and location (*):

_____

_____

_____

Please list the type, dosage, frequency and function of all medications you are taking (*)

Medication	Dosage (mg/day)	Type (function)

Please check Yes or No to the following. Indicate "Yes" for those that apply to you at present or have applied to you in the past (*)

History of chest pain:: ◯ yes ◯ no
History of heart disease or any other hear/valve disorder: ◯ yes ◯ no
History of heart problems in the immediate family: ◯ yes ◯ no
Pacemaker: ◯ yes ◯ no
High blood pressure: ◯ yes ◯ no
Low blood pressure: ◯ yes ◯ no
Difficulty with exercise: ◯ yes ◯ no
History of pathological fracture: ◯ yes ◯ no
Osteoporosis or Osteopenia: ◯ yes ◯ no
Pregnancy (now or within last 3 months): ◯ yes ◯ no
Asthma: ◯ yes ◯ no
Any other disease/problem of the lungs: ◯ yes ◯ no
Diabète: ◯ yes ◯ no
Thyroid condition: ◯ yes ◯ no
High cholesterol: ◯ yes ◯ no
Cigarette smoking: ◯ yes ◯ no
Obesity: ◯ yes ◯ no
Balance or vestibular issues: ◯ yes ◯ no
Seizure disorder: ◯ yes ◯ no
Muscle, joint or back disorder, or any previous injury still affecting you: ◯ yes ◯ no
More than 1 fall in the past 3 months: ◯ yes ◯ no
Any advice from your doctor not to exercise: ◯ yes ◯ no
Recent surgery in the past 12 months: ◯ yes ◯ no

Any chronic illness or condition that may be aggravated by intense exercise?
If yes, please explain:_____

_____

_____

Are you accustomed to vigorous exercise? ◯ yes ◯ no

Is there any reason not mentioned here why you should not follow a regular exercise program?
if yes, please explain: ◯ yes ◯ no

Please make any other comments you feel are pertinent to your exercise program: (*)

Assistive devices used throughout your week: (Check all that apply)(*)

☐ None Wheelchair: ☐ (electric) ☐(manual)
☐ Scooter ☐ Walker (4 wheeled) ☐ Crutches
☐ Cane ☐ Orthoses (AFO) ☐ Orthoses (KAFO) ☐ Abdominal Binder

Other devices used, please list: :

Sensory and motor presentation. Please be as specific as possible.

Briefly describe if there are areas of your body that have altered, little, or no **sensation** (*) :

Briefly describe if there are areas of your body that have little or no **motor control** (*):

Briefly describe any spasticity, tone or tremors (location, time of day, duration, triggers) (*):

What therapies or treatments have you tried in the past, or are currently ongoing? (i.e.massage, acupuncture, physiotherapy, stem cells, etc.)(*)

Do you do any regular activities or exercises to load the affected limbs? If yes, please explain in detail what you do (frequency, duration, types of activities, since when, etc.)(*)

What are your goals, reasons, or health concerns for coming to FSWC Québec? (*)

How did you hear about FSWC Québec?

☐ Health professional ☐ Family/ Friends ☐ Facebook
☐ Internet/Internet/ web ☐ Other

When can you start attending training? (*)

How often do you plan to attend? (*)

What are your preferred days and times of training? (*)

What are other days and times of training that are possible for you? (*)

I am available only: ☐ after 17:00 ☐ weekend

How long do you plan to participate? (*)

Have you had a recent bone density assessment not more than 6 months ago? (*) ◯ yes ◯ no
If so, indicate the results :

If not, we may ask you to get your doctor's opinion after reviewing your application to assess the risk of fractures and adjust the program accordingly

Check the box below. (*)

☐ I have completed this application to the best of my knowledge in order to make known any diagnosed medical problems or characteristics that may increase the risk of health problems, signs or symptoms indicative of health problems and lifestyle behaviors related to positive or negative health. I understand that if necessary, FSWC Québec reserves the right to deny my participation in the program.

I understand that once my application is accepted, I will be required to provide the necessary medical documentation related to the program selected.

Check the box below.(optional)

☐ I agree to receive the monthly newsletter.

☐ I agree to receive occasional information about events, fundraisers, and other promotional communications.