

Clinical Intake Information

Name: _____ DOB: _____

Address: _____

Height: _____ Weight: _____

Hip Width (measurement across top of hip bones): _____

Inseam measurement: _____

Primary Diagnosis: _____

Additional Diagnosis: _____

If applicable, Level of Injury/ASIA impairment scale: _____

Cause of Injury: _____

Knee Contractures: Yes/No? If Yes (please circle): Mild/Moderate/Severe

Hip Contractures: Yes/No? If Yes (please circle): Mild/Moderate/Severe

Other Medical Conditions: (Heterotopic Ossification, etc.) _____

How would you rate your activity level? (Do you play any sports, do you work?)

(please circle) 1 2 3 4 5 6 7 8 9 10 _____
Lowest Highest

Use of Standing Frame: Yes/No? If Yes, please indicate amount _____

Braces (KAFO's, AFO's, etc): _____

FES Bike: _____ Can you self-propel a manual wheelchair? Yes/No

Resting Heart Rate: _____ Blood Pressure _____

Are you on any blood pressure medication? _____

Are you on any medication for Osteoporosis? _____

Skin/Integument, including any current pressure sores _____

Any History of Fractures? _____