

Program Application - Questionnaire Adult Conductive Education® Program

Information on Questionnaire

The purpose of this questionnaire is for us to provide information to the conductors ahead of time so that an assessment can be made. The assessment will allow you to be suitably placed within an appropriate group, so that the maximum benefit can be derived from the program. In addition, the conductors will be able to prepare ahead of time the work series for each person.

Please complete the questionnaire on the following pages as fully as possible. This information will be kept confidential.

Consumer Information

First name:	Initial(s):	Last name:
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Address:

City:	Province:	Postal Code:
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Date of Birth (mm/dd/yy):	Home Phone:	Work Phone:	Pager:
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E-Mail Address:	Referred to program by:
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Emergency contact name and phone numbers

#1 Name of Contact:	Relationship:
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Address:	Home Phone:
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City:	Work Phone:	Pager:
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Province:	Postal Code:	E-Mail Address:
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#2 Name of Contact:	Relationship:
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Address:	Home Phone:
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City:	Work Phone:	Pager:
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Province:	Postal Code:	E-Mail Address:
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Diagnosis

Diagnosis:

Date of Diagnosis (*mm/dd/yy*):

Please describe how you are affected by your condition, and outline any secondary complications. Include details of presentation of your condition such as spasticity, muscle spasms, tremor, loss of feeling, weakness, paralysis or unwanted movement and the parts of your body affected:

Has anyone in your family had the same diagnosis? Yes No

If yes, please specify:

Physical Ability (Please check off the most appropriate answer)

Task	Comments
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I am able to:

- Sit up from bed: without help
 with help
- Turn over in bed: without help
 with help
- Stand up from a chair: independently
 independently with a walking aid
 with help
 not at all
- Walk: independently
 independently with a walking aid
 with help
 not at all
- Get up from the floor: independently
 with something to hold on to
 with help

Do you experience dizziness?

- Often
 Sometimes
 Never

Do you have or experience difficulties in these areas:

- Balance? Yes No
- If yes, do you fall often? Yes No
- Fatigue? Yes No
- Swallowing? Yes No
- Breathing? Yes No
- Speech? Yes No
- Handwriting? Yes No
- Memory and concentration? Yes No
- Seizures? Yes No
- If yes, how often?
 Rarely Every few months
 Monthly Weekly
 Daily

Please describe what happens during your seizure:

Self Care *(Please check off the most appropriate answer)*

	Task	Comments
Dressing:	<input type="checkbox"/> Independently <input type="checkbox"/> Partly independently <input type="checkbox"/> Cannot dress	
Undressing:	<input type="checkbox"/> Independently <input type="checkbox"/> Partly independently <input type="checkbox"/> Cannot dress	
Eating:	<input type="checkbox"/> Independently – with cutlery <input type="checkbox"/> Independently – with a spoon <input type="checkbox"/> Independently – only with finger foods <input type="checkbox"/> Help is needed to eat	
Drinking:	<input type="checkbox"/> Independently – from a cup <input type="checkbox"/> Independently – with a straw <input type="checkbox"/> Help is needed to eat	
Toileting:	<input type="checkbox"/> No difficulties <input type="checkbox"/> Some accidents <input type="checkbox"/> Protection worn during the night <input type="checkbox"/> Protection worn all day and night <input type="checkbox"/> Catherized	

Medical Information

Rehabilitation *Please describe any rehabilitation treatment that you are receiving for your condition (i.e., Physio, OT, Speech Therapy, Personal Trainer, Yoga, Pilates):*

Conditions *If you have had any of the following, please check Yes or No and give the approximate date(s):*

Condition	Date (mm/dd/yy) (approximate)	
Fainting	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Tuberculosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Heart Condition	<input type="checkbox"/> Yes	<input type="checkbox"/> No
High Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Frequent colds	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Allergies (please describe):	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Surgery

Have you had any kind of surgery? Yes No If yes, specify type and date (mm/dd/yy):

Medications Please list all the medications that you are currently taking (name and dosage):

Name of Medication	Dosage

Other Information

Do you use any assistive devices? Yes No If yes, please specify (i.e., cane, walker, brace, orthotics, wheelchair, etc.):

Do you wear glasses or contact lenses? Yes No If yes, when?

Do you have difficulty hearing? Yes No If yes, do you use any hearing aids?
 Yes No

Other Factors

If required, do you have a caregiver/friend who could attend with you? Yes No

Please state any physical or emotional concerns, and detail any other information that you feel should be made known to the conductors:

Declaration and Signature

I hereby state that the above information is true to the best of my knowledge.

Signature:

Date (mm/dd/yy):

Liability, No Action, Indemnity Clauses: Release

Please read and sign the following Exclusion of Liability, No Action and Indemnity clauses. By signing below, you will waive certain legal rights, including the right to sue. Please read carefully.

In consideration of the services to be provided to me by Ontario March of Dimes, I hereby agree as follows:

1. EXCLUSION OF LIABILITY--not to hold Ontario March of Dimes, their members, directors, volunteers, officers, agents, representatives, employees, or assigns ("Releases"), or any of them, liable for any losses, damages or injuries that I may suffer, whether to person or property, howsoever caused, including negligence, breach of contract and breach of any statutory duty or other duty of care, on the part of the Releases, or any of them;

2. NO ACTION--not to bring any action, proceedings or claims against the Releases, or any of them, for any losses, damages or injuries that I may suffer, whether to person or property;

3. INDEMNITY--to indemnify and hold harmless the Releases and each of them from and against all claims, actions, costs, expenses and demands brought by any person in respect of death, injury, loss or damage, whether to person or property, resulting directly or indirectly from my participation with the Releases and the delivery of the projects and services of Ontario March of Dimes.

Declaration and Signatures

I have read and understood this agreement, and I am aware that, by signing this agreement, I am waiving certain legal rights which I or my heirs, next of kin, executors, administrators, and assigns may have against the Releases.

I hereby release and hold harmless all Ontario March of Dimes and any and all other funding or organizations and sources, the owners and/or operators of any facilities utilized and any providers/ conductors of instruction, the agents and employees of any of these parties, from all liability and claims for any injuries or accidents to myself, as well any damages from any cause to any personal property that may occur while participating in the said Conduction Education Program.

Full Name of Applicant (*please print clearly*):

City:

Date (*mm/dd/yy*):

Applicant's Signature:

Witness:

Spouse/Caregiver Signature:

Witness:

Conductive Education Program Publicity Release Agreement

Re: *(name of applicant)*

I hereby grant to Ontario March of Dimes and their assigns, and those acting with their permissions, to produce, use, project and show, and otherwise publish, and copy, distribute, and to make alterations and additions to any photographs, videotapes and sound records produced by Ontario March of Dimes, with or without using my name.

I acknowledge that all copyright in such photographs, videotapes and sound records is the property of Ontario March of Dimes.

I hereby release Ontario March of Dimes and any persons or firms using, projecting or showing any such photographs, videotapes and sound records produced by Ontario March of Dimes with my consent, from any and all claims for damages for libel, slander, invasion of the right of privacy, breach or infringement or copyright including moral rights, or any other claim based on the use of said photographs, videotapes and sound records produced by Ontario March of Dimes.

Print Name:	Signature:	Date <i>(mm/dd/yy)</i> :
Print Name of Witness:	Signature of Witness:	Date <i>(mm/dd/yy)</i> :
Print Name of Ontario March of Dimes Representative:	Representative's Signature:	Date <i>(mm/dd/yy)</i> :