



FIGHTING BACK AGAINST PARKINSON'S

Member Information

Welcome to Rock Steady Boxing! We are pleased to welcome you into our program. To begin, please complete the following documents:

1. Member Information Form
2. PDQ-39 Questionnaire
3. Personal Waiver and Release of Liability

Date _____/_____/_____

Name _____ DOB _____/_____/_____

Address _____

City _____ Zip Code _____

Home phone _____ Cell phone _____

Business Phone _____ Email _____

How did you hear about Rock Steady (circle)? Referral / Media /Website / Other _____

Emergency Contact Information

Name _____

Relationship to applicant _____

Address _____

City _____ Zip Code _____

Home phone _____ Cell phone _____

Email _____

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Parkinson's Information:

Estimated date of diagnosis _____/_____/_____

Which symptoms are you experiencing? (check all that apply)

- Tremors - if yes, which side is most affected?** **RIGHT** **LEFT** **BOTH**
- Postural changes**
- Loss of balance in the last year**
- Slowness of movement**
- Vision impairment**
- Difficultly concentrating or staying focused**
- Fatigue**
- Depression**
- Do you take medicine for Parkinson's? If yes, please list:**

Other Health Questions

Do you: (check all that apply)

- Use a walker, wheelchair or other assistive device**
- Have Deep Brain Stimulation (DBS)**
- Feel dizzy or unsteady with sudden movements**
- Have difficulty getting down or rising from a seated or lying position**

AHA/ACSM Health/Fitness Facility Pre-Participation Screening Questionnaire



History: (check all that apply)

You have had:

- A heart attack**
- Heart surgery**
- Cardiac catheterization coronary**
- Angioplasty (PTCA)**
- Pacemaker/implantable cardiac defibrillator**
- Rhythm disturbance**
- Heart valve disease**
- Heart failure**
- Heart transplantation**
- Congenital heart disease**
- Other heart condition (specify) _____**

Symptoms:

- You experience chest discomfort with exertion**
- You experience unreasonable breathlessness**
- You experience dizziness, fainting or blackouts**
- You take heart medications**

Other health issues:

- You have diabetes**
- You have asthma or other lung disease**
- You have burning or cramping sensation in your lower legs when walking short distances**
- You have musculoskeletal problems that limit your physical activity**
- You have concerns about the safety of exercise**
- You take prescription medication(s)**
- You are pregnant**

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Notes and questions for test administrator

What symptoms of Parkinson's are you experiencing in your daily life?

Have you been diagnosed with any other medical problems we should be aware of?

What do you wish to gain from joining Rock Steady Boxing?

Do you have questions or concerns about the program before we get started?

Additional administrator notes: _____

Media Release

I _____ (member name) allow Rock Steady Boxing to publish or broadcast my image/likeness and/or name for promotional purposes associated with Rock Steady Boxing.

Signature _____ Date _____